Handbook *of* Psychiatry

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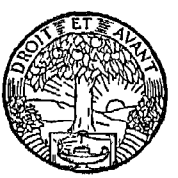

Philadelphia London Montreal
J. B. LIPPINCOTT COMPANY

ECOND IMPRESSION

PRINTED IN THE U. S. A.

To the memory of

DOROTHEA LYNDE DIX

LAYWOMAN

who single-handedly wrought
the greatest reform in
history in the hospital
care of the mentally ill.

Preface

Through the centuries, man has evinced deep interest in the problems of human behavior, and especially in the phenomena to which we now refer as mental disorder. Beliefs in demoniac possession, and the interpretations, once prevalent, of aberrant behavior as supernatural punishment for sin led to systematic neglect and abuse of the mentally ill which are almost unbelievable.

More recently, various motion pictures, magazine articles and books, some of the "exposé" variety and some of them in the nature of handbooks, have served to indicate a widespread interest in the subject of psychiatry, an interest which has been intensified by the numerous psychiatric casualties of the recent war.

The authors have here attempted to present, in a simple and unsensational manner, the elements of the varied types of mental disease, their causes, symptoms and prospects Therapy has been sketched in general terms only, for the authors have not desired to *offer encouragement to self-treatment* Rather, *they have wished* to clarify for the nontechnical reader the substance of mental disease and the proper attitudes toward it It has been their hope that the college student, the nurse, the average man or woman who has mentally ill relatives or friends, and perhaps even the practicing physician who has shied at the more technical volumes on the subject, may gather from this book some measures of understanding which will allay some of his misgivings and redound directly or indirectly to the welfare of the half million (and more) patients in the mental hospitals of the United States, as well as of the unknown thousands of neurotics in the community.

Shortly before the manuscript of this volume was completed, Dr Winifred V Richmond died She was a wise and understanding student of human personality, possessed of the gift of presenting facts simply and readably Her passing was a great loss to the literature of human behavior Her surviving co-author is happy to have the privilege of completing this book and offering it to the public as a tribute to her memory

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Acknowledgments

The courtesy of the following publishers to quote from books and journals is gratefully acknowledged

Administrative Office of U S. Courts (Federal Probation)
Dr. V. C. Branham (Journal of Criminal Psychopathology)
Children's Bureau
Dr. Clarence B. Farrar (American Journal of Psychiatry)
Federal Probation Quarterly (Mr. Henry P. Chandler)
Harcourt, Brace & Co., Inc.
Harper & Bros.
Paul B. Hoeber, Inc.
Dr. Nolan D. C. Lewis (Journal of Nervous and Mental Diseases)
Longmans, Green & Company
Dr. Lawson G Lowrey (American Journal of Orthopsychiatry)
The Macmillan Company
W. W. Norton & Co., Inc.
Oxford University Press
Public Health Service Publications Office (U S. Public Health Service)
Rinehart & Company, Inc.
State Hospitals Press, Utica, N. Y.
Charles C. Thomas, Publishers
The Viking Press, Inc
West Publishing Company
Yale University Press

Acknowledgment is also made of the great helpfulness of Miss Betty Reavis in the preparation of the index.

The approval of this volume as one of the Non-Technical Scientific Series of the American Association for the Advancement of Science is deeply appreciated.

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What This Book Is About

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Psychiatry is one of the youngest of the medical specialties, although there never has been a time, so far as we can discover, when there have not been people whose behavior was so different from that of their neighbors that they were regarded with fear and suspicion, and steps taken to protect the group or the community from them. However, until quite recently the doctor has not been the person consulted Abnormal behavior, and what we would now call mental illness and disease, were believed, for long ages, to be an affliction sent by a god, or possession by evil spirits, or the result of witchcraft When such beliefs were prevalent it would not be the doctor who would be called upon to treat these conditions, but the priest, or sorcerer, or medicine man From the time of Hippocrates, the Greek Father of Medicine, on down there always have been physicians who were interested in abnormal behavior and mental maladjustments, who attempted to study and treat the persons showing them However, it was not until the medical and psychologic discoveries of the last one hundred years gave the doctor the tools to work with that he could make much headway in the understanding and the treatment of mental disorders. Within that time psychiatry has made tremendous progress Chaos has been made into order by the classification of symptoms; the causes of many baffling states have been discovered, successful treatments for many of them have been instituted and better methods of caring for the mentally ill and getting them back into the community have been devised.

Psychiatry has by no means confined itself to the study and the treatment of only the acutely ill—those patients who must be cared for in mental hospitals. As it has learned more and more, psychiatry has come out of the hospital and concerned itself with child-

rearing and family relationships, with education the cultural environment, and has developed a preventive program within the public-health field It studies and treats children with behavior disorders, delinquents and criminals, the misfits in our society, and that vast army of sufferers from physical and mental complaints who still are not sick enough to be hospitalized Zilboorg* suggests that the term *medical psychology* be used in this broad sense and the term *psychiatry* be reserved to designate that branch of medicine which deals with the more severe mental abnormalities Perhaps, in years to come, this usage may obtain, but at present psychiatry is the term most frequently employed to cover the study and the treatment of any form of personality defect or disorder.

PSYCHIATRY AND PSYCHOLOGY

A great deal of confusion exists in the popular mind in regard to the differences between psychiatry and psychology and the work of the psychiatrist as distinguished from that of the psychologist

Psychology is a magic word to many people It is looked upon as the key to all kinds of mental mysteries and personality problems. If a person will "study psychology" he can find out about himself, how to control his "subconscious mind," how to become attractive and popular, how to overcome his bad habits and turn his failures into successes At least, this is what is promised by the numerous quacks and fakers who call themselves "psychologists" or profess to use psychology, who peddle anything from diet and fortunetelling to new religions. That some people who read their books or listen to their lectures or radio programs are helped, momentarily at least, is certainly to be credited to psychology, though not in any way that would please the self-styled "psychologists" themselves

Unfortunately, there are as yet no legal requirements for the psychologist, except in a few of our most progressive states Usually he does not have to be licensed to practice, and though in the majority of states he must have certain educational qualifications in order to teach psychology in state-supported schools or to hold a position in an institution, in most places there is nothing to hinder anyone from calling himself a psychologist and hanging out his shingle. It is not uncommon to see in advertisements or on signs a combination such as "clairvoyant, hypnotist and psychologist"

* Zilboorg, Gregory· A History of Medical Psychology, New York, Norton, 1941, p 12.

We have the card of a Dr. So-and-So, "Psychologist," who announces his readiness to treat "all incurable diseases," such as "heart trouble, cancer, falling womb, asthma, and constipation." These people bring psychology into disrepute and hinder it from gaining the place in public esteem which it deserves

What, then, is psychology, and how does it differ from psychiatry? Historically speaking, psychology is the science of the mind. It probably grew out of man's speculations about his own mind, about his thoughts and feelings and dreams, and was not separated from philosophy until very recently Philosophy, in turn, is that branch of human knowledge which studies man in his relation to the universe, or, as the dictionary puts it, "the study of the principles underlying human behavior" Everybody has direct experience of his own thoughts and feelings, and though most people are very vague about their "minds," they have no difficulty in recognizing thought and feeling as mental phenomena As a matter of fact, we do not actually know what "mind" is, but that does not hinder us from using our minds, studying them, "losing" them and "recovering" them again. This is exactly the way we have in regard to numerous other natural phenomena—electricity, for instance, with which we perform seeming miracles without in the least knowing anything about its true nature We know how it works, how it functions, and that is all we know about mind—perhaps all we ever can know As has been remarked, we are only beginning to scratch the surface of knowledge regarding how the mind works.

With so much to learn about a subject, it is only natural that there should be a great many different ways of investigating it, and so there are numerous "schools" or kinds of psychology, each studying some aspect of mental function, or guided in its works and research by some particular theory Sometimes psychology appears to have gone far afield from its original interest in mental events Much of its work seems more strictly physiologic, as in studies of the nervous system, of the endocrine glands and of the behavior of animals under laboratory conditions Many of its results, too, are expressed in mathematical language, so that it may be difficult for the untrained layman to follow it. All this, however, has a bearing on mental behavior

This is not the place for a discussion of the various types of psychology, but we must note that while there are many "psychologies" which, to the layman, seem to offer little that helps him to understand himself, there are others whose business is exactly that.

Some of them are: the psychology of childhood and adolescence; educational psychology, which studies how people learn and how best to teach them, vocational psychology, which studies aptitudes and abilities and how to fit square pegs and round ones into the proper holes, industrial psychology, which studies the reasons why people succeed or fail, are happy or unhappy, in industry A book published during the war, *Psychology for the Fighting Man,* brings together a great deal that psychology has learned about how the human mind works and is as informative for the civilian as for the soldier.

Clinical psychology studies the mental make-up of an individual. How much and what kind of intelligence has he, what are his abilities and disabilities, his aptitudes and talents; what is his emotional make-up and its relation to his behavior; what are his personality assets and liabilities? This is the kind of psychology that is employed in clinics and hospitals and in institutes and research centers which are found in some of the larger cities.

Germany, taking from the discoveries of other countries, as well as her own, has been developing for years the art of "psychologic warfare." Propaganda is one aspect of this warfare, but so is the application of the psychology to the training and the selection of officers, to the development of soldiers to the highest pitch of efficiency, and to the control of the civilian population toward the ends envisaged by the leaders She has gone much further than any other country in applying the principles that psychology has discovered, though for several years Russia also has been making extensive use of psychologic knowledge.

In general, we may say that the years between the two World Wars saw an increasing tendency to put psychology to work. As more and more has been discovered about mental function, that knowledge has been applied to an increasing number of human problems The psychologist has gone into schools and colleges, into courts and prisons, into institutions and industry, often raising more problems than he has settled, but nevertheless still advancing our knowledge of human beings Hundreds of psychologists served in the armed forces, culling out the men who were not "mentally fit" to be soldiers, or engaging in research upon certain aspects of the human problems connected with war It is certain that, in the future, applied psychology will have more to do than ever.

How, then, does psychology differ from psychiatry? The two fields overlap largely, since psychiatry also "studies the mind," and

a great deal of its work is, strictly speaking, psychologic, but psychiatry is a medical discipline and its emphasis is upon treatment. The term "psychiatry" comes from two Greek words which mean *mental healing*. It was only natural that the doctor should expect to find the cause of mental disease in the body, so the means of treatment used at first were physical. Medicine, operations, diets and various other physical measures were employed, but not until more was learned about mental illness in general, its causes and its different manifestations, could much headway be made with any kind of treatment

The twentieth century has seen the general acceptance by both psychology and psychiatry of the "organismic theory," the doctrine that there is no separation between mind and body, that they are merely different aspects of the same organism There is not a mind *in* a body, or a mind *and* a body, but a mind-body We can fasten our attention upon either the one or the other, but whenever we are dealing with an actual human being we are dealing with a mind-body organism, and both aspects must be taken into account in understanding him This doctrine had been advanced more than once in earlier times, but like many other theories in the history of human thought, it had to await the development of experimental methods and the scientific approach before it could be verified

Thus we can say that modern psychiatry deals with the whole man, with the total personality It takes from both medicine and psychology, and its emphasis is upon treatment The psychiatrist is a medical man who has specialized in the study and the treatment of mental disorders or, as it is more and more coming to be phrased, personality disorders If he wishes to be accredited and accepted by the profession he must serve a long apprenticeship, usually in a hospital, and pass special examinations, thus psychiatry has been put upon a par with the other medical specialties

Psychiatry has not always been interested in the individual There was a long period in the nineteenth century when it was getting on its feet, so to speak, when its chief interest was not in the man and why he was sick, as it is today, but in the sickness itself The symptoms of mental diseases, their courses, outcomes and the classification of the various forms of mental disorders into groups with similar causes or similar symptoms, engaged the best minds of the profession The great name here is that of Emil Kraepelin, who is often called the father of psychiatry His descriptions of symptoms and behavior in the different mental disorders

are classical, and his classification has formed the basis for all later ones. This was a necessary step to take, as it is in all science Until order had been introduced into the confusion that always had existed in regard to the various abnormal mental states, until they had been given names and what was known of their causes and probable outcomes had been brought together, little progress could be made toward an understanding of their psychologic aspects

PSYCHOANALYSTS

While Kraepelin and his co-workers were observing and classifying, other workers were studying individuals and attempting to find out what was back of their peculiar behavior. Sigmund Freud, a Viennese physician, in the course of his treatment of patients who were not mentally ill in the usual sense, but had all sorts of ailments and conditions that prevented them from living normal and well-adjusted lives, developed a method of exploration of the mental life which he called *psychoanalysis.* Using this method, he and his followers worked out the beginnings, at least, of a new system of psychology, which has not only had a profound effect upon psychiatry, but upon all contemporary thought as well Today even those psychiatrists who do not accept psychoanalysis in its entirety make constant use of its concepts, and all of us, even without knowing it, use many of the ideas and the insights it has given us.

Freudian psychology stresses the "unconscious," that part of our minds which we usually know nothing about, though we come in contact with it in dreams and daytime reveries, in slips of the tongue, or in behavior which we did not intend but which breaks through nevertheless. We can see its effects in the mentally ill when the reasonable, civilized part of the mind often seems submerged and the unconscious takes possession Psychoanalysis has discovered many of the principles that guide personality development, the mechanisms, or dynamisms, by means of which the mind works, and the hidden motives that prompt so much of our behavior. However, because it had so much to say about sex, psychoanalysis raised a storm of opposition and was bitterly set upon by physicians, psychologists and many psychiatrists. Even today, fifty years after Freud's publications began to appear, it is still a controversial subject, far from being accepted in its entirety by a great many psychiatrists, although many others accept and practice it.

There are other names in psychoanalysis not so famous as

Freud's. Jung and Adler were two of his earlier students, both of whom broke with him and established "schools" of their own. Jung called his method *psychological analysis* and it has much in common with Freud's, though its underlying philosophy is different Jung first introduced the terms *introvert* and *extrovert* to describe certain types of personality, though he probably would not recognize his concepts as they have been developed by American psychologists. Adler called his method *individual psychology* and placed stress upon the strivings of man to overcome his inferiorities and thereby gain power and supremacy. Adler had a great influence upon education in Austria after World War I, and through his activities in this country he also influenced many educators here.

There are a number of practicing psychoanalysts in this country, especially in the larger cities For the most part, they follow Freud, though there are some "Jungians" and "Adlerians" Generally, they engage in private practice, although there are a few psychoanalytic institutes and their number probably will increase As yet the analyst is not found often in the mental hospitals, and many psychiatrists do not believe that psychoanalysis is suited for use in the more severe mental disorders, though others welcome it as a research instrument, at least

The psychoanalyst was originally a medical person, and strenuous efforts have been made, especially in this country, to keep him so The "Psychoanalytic Societies" admit no one who is not a properly qualified physician, and so far they have been the only training centers Recently a New York university has announced the institution of a course in psychoanalysis to which only physicians will be admitted The reason for this is not far to seek. it is to prevent the unprepared and the unqualified from undertaking to practice psychoanalysis, for in the hands of such persons it may be a dangerous procedure. The "parlor analyst" will not be likely to recognize the signs of physical illness or to know their importance. Nor may he know how to handle the mental symptoms that emerge in the course of his treatment; an actual mental illness may develop, or the patient may commit suicide

There are, however, a number of lay analysts. Freud himself gave his approval to the properly qualified lay analyst, and his daughter, Anna Freud, a leading child analyst, is not a medical person. Some of the better known names among European analysts are those of psychologists rather than physicians Neither Jung nor Adler required his students to be physicians. Many nonmedical Eu-

ropeans, trained in psychoanalysis before the rise of Hitler, are now in this country. Nevertheless, one should scrutinize a prospective analyst, lay or medical, for that matter, very carefully before committing oneself or one's friends and relatives to his hands.

Psychoanalysis is a long, hard discipline It requires years of training and practice before one can hope to be really proficient in relieving patients of their mental and emotional difficulties. Its methods are deceptively simple The patient learns to "associate" or to say out all the things that come into his mind during the analytic hour and to recall his dreams. In this way much material is brought up, much of it irrelevant to the patient's illness But the analyst must know how to discover what is relevant, and how to interpret it so that the patient can use it to further his recovery This procedure is a subtle and difficult task and requires a wide range of knowledge on the part of the analyst, as well as definite personality qualifications A great many people never can learn the technic successfully

How is it, then, that one sees "psychoanalysts" advertised, usually with extravagant claims, in the telephone and city directories of every large city? These people are again the quacks and the fakers, knowing nothing of psychoanalysis Since there is no law against it, they can call themselves "analysts," practice hocus-pocus and deceive the ignorant into paying them large fees If the "analyst" is kind and sympathetic, and if the "patient" has been seeking someone to whom he can unburden himself, the latter may temporarily, at least, feel much relieved, but he has not been psychoanalyzed

DEFECTS AND DISORDERS OF THE PERSONALITY

We have defined psychiatry as the medical specialty which deals with mental or, as it is coming more and more to be phrased, personality defects and disorders. We may now inquire what these disorders are

The answer can apply only to our own modern society, for what is considered normal in one time or place becomes abnormal in another. Our ancestors held beliefs—and acted upon them—that we would consider delusional, false and out of keeping with sanity. There are "cultural pockets" in our own country where beliefs are held that in another stratum of society would mark a person as abnormal. Thus, in the voodoo practices of some Southern Negroes,

the "hexing" of persons in the Pennsylvania hills, and the religious excesses of certain groups in the Southwest, these people, no matter how abnormal their conduct may appear to us, are thinking and behaving as they have learned to do from their families and associates.

Unusual or abnormal behavior always has been the concern of the law, which has its own standards for judging it As long as a person gives evidence that he knows the difference between right and wrong, according to the standards of his society, he is considered responsible for his behavior and therefore "sane" The psychiatrist has quite a different set of standards He judges by how the person's thinking has deviated from what is usually considered normal, how far "out of touch with reality" he is If he is mentally ill he apprehends the world, or some portion of it, at least, in a distorted fashion. This is sometimes very difficult to determine, so psychiatrists may differ in regard to whether a given person is or is not "insane" (*psychotic* is the medical term) "Doctors disagree" more often in regard to mental than to physical illnesses because the symptoms are sometimes very elusive, or the person may know how to conceal his abnormal thoughts and feelings

The major mental disorders, or what used to be called "insanity," in which the patients are, in some respects at least, out of touch with reality, naturally engaged the attention of psychiatry first The medical term for these conditions is *psychoses*, and the person suffering from one of them is said to have a *psychosis* or to be *psychotic* These sicknesses or illnesses of the mind are no more disgraceful or dreadful than the sicknesses of the body We shall see later that they are not all unpleasant; indeed, many of them are rather happy states to be in It is hard for the layman to grasp that a person may be psychotic and yet appear quite normal, may be able to continue his work and to converse about ordinary topics in a normal fashion. Every mental hospital has patients who move freely about the grounds, do their share of work and are always being mistaken by visitors for employees Many jokes are told in relation to them. Perhaps the best known is the one about the man who was engaged in conversation by a visitor, who found him intelligent and charming and began to wonder why such a man should be confined in a mental hospital

"You see that fellow over there on the bench?" remarked the patient, "he thinks he is Jesus Christ."

"How strange!" said the visitor.

"Yes, isn't it preposterous! *I am Jesus Christ!*"

There are different ways of grouping the psychoses. One classification in use since Kraepelin's time is divided into the *organic,* or those associated with some injury or disease of the brain, the *toxic,* following upon the taking into the body of some substance that poisons the brain cells, and the *functional,* or those for which no physical cause has as yet been found. There are more exact classifications, and as more and more is learned about mental function, finer and finer distinctions are made, so that the "differential diagnosis" is now an elaborate affair. But for the purposes of this book the simpler classification noted above will suffice.

The minor mental disorders are called by the psychiatrist *neuroses* or *psychoneuroses.* In these conditions the person may have any number of peculiar thoughts or emotions that force him into unusual behavior, but he does not lose touch with reality as the psychotic does; he still sees the world approximately as the rest of us do. The world is full of neurotic people and probably none of us is entirely free from what might be called neurotic traits. Every doctor's office is filled with neurotics of one type or another, and it is variously estimated that they form from 30 to 50 per cent of the average physician's practice.

In their milder forms neuroses are not incapacitating but, on the other hand, they may be so severe and crippling that it becomes necessary to admit the sufferers (which such cases almost always are) to a mental hospital, yet, since they are not technically "insane," many psychiatrists refuse to certify them. There are no public institutions for neurotic cases, although they are admitted to the veterans' hospitals. They fill up the rest and convalescent homes and the private sanitariums, they abound in our prisons and reformatories.

The extent and the severity of the problem of neurosis has not been recognized, even by the psychiatrist, until comparatively recently. However, these problems are not, except in the severer cases, predominantly medical. They are social and educational, and as such are largely in the hands of the layman. The psychiatrist can advise and guide, but he must leave to the layman the carrying out of his suggestions, as in the control of infectious diseases the doctor must rely upon the co-operation of the layman in carrying out the necessary preventive and educational measures.

A third group of cases of peculiar behavior that do not fit into

either of the other two categories is called by the psychiatrist *psychopathic states* or *psychopathic personalities*. These terms cover a large variety of behavior which continues to baffle everyone, including the court and the psychiatrist The group includes the people sometimes called "moral imbeciles" (a classification still used in England) because, no matter how intelligent they may be, they seem to have no moral sense, and no amount of teaching or punishment serves to develop it. Until very recently these people have been considered by everyone willfully antisocial, and even now they are seldom considered psychiatric cases by the general public. Incorrigibles, tramps, vagrants, delinquents and criminals, the uncontrolled and the unsocialized, are diagnosed as "psychopaths" for want of a better term to cover their behavior. It may well be said that the term designates our ignorance, undoubtedly there is a cause for such behavior, but we do not know it yet It is one of the so-far unsolved problems of psychiatry

Mental disorder must not be confused with *mental defect* The latter term implies a lack and is properly used of people whose intelligence has not developed to a normal degree. As we say, they are "feeble-minded" What intelligence they have may function in a normal fashion but, on the other hand, there may be abnormal function at any level of intelligence, at least above the very lowest. A psychosis in a mental defective, however, is likely to be a rather colorless affair, since the patient does not have a large stock of ideas with which to build up false notions about reality Mental defect is a very important social problem, as well as an educational one, nevertheless, in certain of its aspects it is first of all a medical problem It deserves inclusion in any discussion of psychiatric questions

We may say, then, that psychiatry, beginning as the medical specialty dealing with mental defects and disorders, finds itself in the twentieth century concerned with total personalities It draws from medicine and psychology and from any other source that offers help in understanding its subject It seeks for causes and it is much concerned with treatment and prevention It attempts to enlist the interest of the layman, because without his intelligent co-operation preventive measures cannot be instituted and carried out Psychiatry does not pretend to have all the answers to the riddle of human nature, but it has enough of them, it believes, to enable it to take a large share in building up a saner and therefore a better world

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2

The Causes of Mental Disorders

No question is more frequently asked the psychiatrist in discussions with people generally than that concerning the causation (the etiology, as the doctor says) of mental illness and personality disorders There are many popular notions as to causes, but few of them can be proven upon examination A dogmatic answer can be given only in regard to the organic and toxic psychoses As to the causes of the other and larger groups of functional neuroses and psychoses, psychiatrists are not yet in full agreement Let us look first at some of the popular ideas about causation and then at the various psychiatric theories that are current today

SOME POPULAR FALLACIES

Heredity

Heredity is most often blamed by the layman as a cause of mental disorder. We frequently hear the expression that "insanity runs in families" However, heredity is not the fairly simple matter that it appears to many people On the contrary, it is an exceedingly complex matter, and all its secrets have not been penetrated yet. In the last quarter century a great deal of work has been done upon heredity in animals, guinea pigs, rats and insects, especially the fruit fly. These creatures multiply so rapidly that

several generations can be studied (in the case of the fruit fly, thirty-five generations in one year), and extremely important discoveries have been made about the mechanisms of heredity, which undoubtedly hold good in man as well There is no reason to believe that heredity works one way in animals and another way in man.

It seems certain that nothing is inherited which is not carried in the genes, the genes being elements in the chromosomes which form the nuclei of the cells in our bodies When an egg cell and a sperm cell unite, the genes do the work of producing a new creature These particular cells (egg and sperm), which are often called "germ cells," have been set apart and isolated from the rest of the body—the eggs in the ovaries, the sperms in the testicles—and very little that happens to the body can reach them. Changes are produced in the germ cells of animals by x-rays, and there is some evidence that the excessive use of alcohol produces degenerative changes; but the ordinary experiences of life, diseases, accidents, and so on, produce no changes and are not inherited

When mental diseases are inherited they are due to defective genes, which in their turn have been inherited These gene defects, capable of producing defects in the body, are very common All of us carry in our cells many defective genes, but nature strives for normality, if one parent carries a defective gene and the other a normal one, the normal gene is *dominant* and does the work of development, while the other one is *recessive,* that is, lies dormant but is not lost It is passed on to the child, and if that child mates with a person who carries the same type of defective gene, the defect will, in all likelihood, appear in some of their offspring This is what happens in hereditary mental defect When both parents are defective, most of the children are defective However, mental defectives also come from normal parents—Jennings* estimates that for every mentally defective person in the community, there are thirty "carriers," that is, normal persons who have the defective genes but will not have defective children unless they happen to mate with persons who also carry defective genes for the same traits †

* Jennings, H. S The Biological Basis of Human Nature, New York, Norton 1930, p 241

† A few rare diseases of the nervous system that are directly inherited, according to the Mendelian law, that is, 50 per cent, on the average, of the offspring of a parent who has the disease will be afflicted They are degenerative diseases and invariably result in great mental dilapidation and death Huntington's chorea is the best known of these

Our knowledge of the part that heredity plays in mental illness is far from complete. Mental hospitals in this country and abroad have been gathering statistics for a long time. The family history of every patient who enters is investigated, so far as possible, but this information is usually obtained by questioning the relatives, who may know little about it or may be averse to telling what they do know Besides, the average person is not qualified to give this information accurately. He may know of relatives who are or have been in hospitals, but he seldom knows the diagnosis, and often he is repeating only hearsay As people become more intelligent on the subject of mental disease we may expect these sources of information to become more reliable.

A considerable number of studies on heredity in mental disease have been made by psychiatrists or by trained social workers, and here we may expect more accuracy, though in many of them the cases have been too few to make conclusions significant Others have had to depend upon the judgment of untrained observers, relatives or neighbors, who reported what they had heard or thought Social heredity, or the influence of the environment in which the person has developed, is too often left out of account Thus the famous study of the Kallikak family, which semed to prove conclusively that feeble-mindedness is inherited down through the generations, is no longer accepted uncritically, there were too many sources of error in it, and too many lines of investigation were neglected A great number of statistical studies have been made on the inheritance of the functional psychoses, some of them, under the direction of psychiatrists, have been carefully controlled and are more reliable than the others Pollock,* summarizing one such study in the state of New York, says:

> On the basis of family statistics of mental disease, we are now in a position to say that, though no specific law of inheritance of mental diseases has as yet been proven, it does seem highly probable that there is a generalized familial basis for such disorders The chance of developing a mental disorder is greater in such families than the corresponding chance for the general population.

Common observation, which is confirmed by what trustworthy statistical studies we have, would indicate that there are families in which nervous conditions of one kind or another are more prevalent than in others. Some families seem to inherit what has been

* Pollock, Horatio M. Mental Disease and Social Welfare, Utica, N Y State Hospitals Press, 1941, p 130.

called "poor biologic material." Both physically and mentally they are poorly adapted to meet the stresses and strains of life. Other families produce some cases of mental disorder and at the same time cases of high talent or even genius. It is also true that families of tainted stock sometimes regenerate themselves. Their members mate with persons of healthier stock, and their descendants are healthy. "There is evidence," say Henderson and Gillespie,* "that nature may mend, rather than end, a psychotic strain" Pollock† says, "Inferior human stock may still be enabled through proper nurture, to achieve a life of a fair degree of usefulness" Mott‡ sums up the matter by saying, "A bad stock is one where are found a large number of members exhibiting various forms of degeneracy besides insanity, e g, feeble-mindedness, epilepsy, criminality, pauperism, inebriety, in fact, a general low standard, mental and physical, in stem and branches of the family tree" Such families are the "poor biologic material" mentioned above

In general we may conclude that, while heredity undoubtedly plays a role in the causation of mental disorders, it is not in the fatalistic fashion that many people imagine Because a person discovers that an ancestor or a near relative suffered from a functional mental disorder, he need not decide that he or other members of his family are fated to develop the same condition On the basis of present knowledge, all we can say is that families in which one or more members suffer, or have suffered, from a functional mental disorder are somewhat more likely to produce children some of whom may develop similar conditions than those families in which no such disorders are found

Overwork and Fatigue

Very commonly the layman is inclined to blame overwork and fatigue for causing mental breakdowns. Often enough this appears to be the cause, but it is usually a mistaking of symptoms for causes People do overwork, prior to and during the first stages of a mental illness, but when closely scrutinized the overwork appears to be a symptom of the approaching breakdown rather than its cause. As we shall see later, there are conditions in which the person feels impelled to work faster, going without sleep and even food, and other cases in which the worker is driven by fear and anxiety to work

* Henderson, D. K, and R. D Gillespie· A Textbook of Psychiatry, ed. 6, New York, Oxford, 1944, p 44

† Pollock, *op cit*, p 44

‡ Quoted by Henderson and Gillespie, p. 44.

harder. When the breakdown comes, it is natural to attribute it to the work, but the emotions are the real culprits Fatigue itself is a warning signal, and when it is disregarded one may work to the point of physical exhaustion; normally, however, when the body has recuperated there are no mental symptoms left behind This is not saying that when one has worked to the point of fatigue the mind is as alert and quick as when one is fresh and rested; on the contrary, all studies of fatigue have shown that work output falls off and accidents increase toward the end of work periods or as hours of work are lengthened Everybody knows that automobile accidents are much more frequent when the driver is fatigued after hours of driving. We also know that when it is necessary, as in wartime and other emergencies, men and women perform prodigies of work without suffering breakdowns. The cases of "combat fatigue" of which we hear in soldiers are only further proof of this point They occur in the men who have had an overdose of horrors, who have fought and worked and gone without sleep to the point of physical exhaustion, and in situations in which fear and anxiety, often to an extreme degree, are present Fear and anxiety, added to the physical exhaustion, produce the breakdown These cases, however, are different from the mental disorders we have been discussing A large percentage of them recover in a fairly short time when they receive immediate treatment They do not become permanent nervous or mental invalids

The old idea that fatigue creates toxins or poisons in the body, which in turn cause nervous illnesses, has been completely discredited Overwork in itself kills no one, apparently, but worry and excessive anxiety can bring on mental and nervous symptoms However, abnormal worry and excessive anxiety do not make their appearance in everyone There are people who seem predisposed to worry, who become greatly upset by events that others take in their stride, these people "lose their minds" seemingly through overwork, or unhappy love affairs, or the failure of cherished plans and ambitions Healthy people who have learned good mental habits can pick up the pieces and go on when these things happen to them.

Sexual Excesses and Bad Sex Habits

Until recent years even psychiatrists counted sexual habits among the causes of mental illness. A great many mental patients masturbate openly and excessively, and the masturbation was thought to be one cause, if not the only one, of the mental break-

down. Here again symptoms have been mistaken for causes We now know that masturbation is practically universal in early adolescence, at least in boys, not only in our culture but among all peoples; and if it caused insanity the human race would have become insane, and therefore probably extinct, long ago. The feelings of worry and guilt which may be attached to the habit (and also the daydreaming connected with it, which is likely to arouse the greatest feelings of guilt) can and often do upset a sensitive adolescent so that his school work suffers and he becomes shy and withdrawn The normal youth comes out of this period without suffering a nervous breakdown, and here again we have to blame his emotions for his bad time rather than the masturbation

Sexual difficulties of all sorts accompany mental illness A greatly increased drive or a greatly diminished one, impotence, perversions, and other abnormal manifestations are found in different types of mental illness They are part of the picture, but not causes —at least, not in any sense in which the layman thinks of causes

Recently we have heard a great deal about the evils of sex repression and the lack of sexual satisfaction. Partly, this idea is due to the smattering of Freudian doctrine that has become common knowledge and, taken outside its context, is completely misunderstood and misapplied Partly, also, it is a hangover from the days of our ignorance about the psychology of sex, when the importance of the emotional factor and the attitudes one has toward the matter were not understood

It is not uncommon for a single woman who is "nervous" and poorly adjusted to be advised, sometimes even by physicians, to marry or to go out and have sex experience as a "cure" for her nervousness. It seldom works, and when it does it is because marriage has given her new interests and responsibilities, forcing the energy which had been focused upon the self into healthier channels Usually, the last state of that woman is worse than the first. Guilt feelings and submerged emotions come out in full force, the husband's life is made miserable, and the children, if there are any, are started on a career of maladjustment and unhappiness. Or, when sex experience without marriage is sought, personality factors unknown to the advisor may bring disaster. Anyone in the psychiatric field who works with "nervous" or maladjusted women knows such cases. A single illustration will suffice. Miss N, a schoolteacher of forty, strictly brought up and still under the thumb of her widowed mother, became highly nervous, sleepless, tormented by

sex thoughts and feelings and fears of suicide. She was told by a doctor, whose advice she sought, that she was perfectly healthy but too repressed. "Go out and have a fling," he told her "Get a man and have a good time" She took his advice and had an affair with a very unsuitable man She was shocked by the experience, considered herself degraded, became greatly upset and attempted suicide

If sex relations were merely the satisfaction of a physical urge, as they are in animals, the matter might be different; but in people the sex function is so tied up with emotion, so much at the mercy of thoughts, beliefs, prejudices, taboos and superstitions, that in very many instances the instinct itself cannot function in a normal manner. The whole personality is involved, not merely the sexual function.

Physical Illness and Affection of the Brain

There is a widespread belief that all mental illness is due to some physical disease or injury and that operation, medicine, x-ray treatments, or some other form of physical treatment ought to cure it Since medicine always has been accustomed to look for bodily causes in illness, psychiatrists never have ceased to search for obscure physical causes, and the history of psychiatry is full of discarded theories and of treatment based upon the supposition that this or that was wrong with bodily function The use of *shock therapy* is a recent example of the attempts of psychiatry to find a physical means for combating mental illness It may be, as knowledge of the human organism advances and more refined methods of research are developed, that physical causes will be found for mental conditions that now seem to have no connection with them. At present, the mental disorders for which a physical cause can be proved are, as noted above, the organic and the toxic psychoses These, as we have seen, follow some disease or injury to the brain itself They may be only temporary, as in the delirium of fever or in alcoholic intoxication, or they may result in permanent damage and even death, as in untreated paresis (a disease that occurs when syphilis attacks the brain), in some cases of epilepsy, or in old age when degenerative changes take place in the brain A toxic psychosis may follow childbirth, clearing up when the infection is removed When it does not, or when there is no infection, and the woman continues to suffer from a psychosis, we can only consider the preg-

nancy and the childbirth as the "precipitating cause" (see pp. 21–22) in a personality that was ready to break when an unusual strain was placed upon it *

But in the functional psychoses, which form the majority of hospital admissions, and in the great group of minor disorders or neuroses, any connection that they seem to have with bodily injury or disease is purely an associative one and not causative.

Other Causes

As to other conditions that seem to the layman to cause mental breakdowns, few of them are blamed by the psychiatrist. The "mad tempo of modern living" is often accused of producing nervous breakdowns, but when we seek for actual proof it is hard to find. Judging from statistics from New York state,† where State care of the mentally ill has been in operation longer than in most places, there has been a slight increase in hospital admissions, which have been rising slowly since the year 1910 However, this increase is largely limited to the age groups over 40 and is particularly marked in the age group over 60 Cases of *arteriosclerosis* (high blood pressure) have increased many fold from 1910 to 1936 There may be factors of stress and strain at work here, or the increase may be due to the fact that many more people are living in the age when the presenile and senile psychoses develop. Psychoses due to alcoholism, which showed a steady decline from 1910 to 1920, began increasing a year after prohibition, and have been increasing ever since Though the strain of modern life is often blamed, an equally good case can be made out for other causes like alcoholism.

Thus we may say that the popular ideas as to the causes of mental illness are relics of the days of our ignorance concerning it, and not many of them are substantiated by scientific investigation

PSYCHIATRIC THEORIES REGARDING THE CAUSATION OF MENTAL DISORDERS

The history of psychiatry is full of theories that have had a vogue and a following for a longer or shorter time and had to be

* See Chaps 5–8 for further discussion of these conditions

† Landis, Carney, and James D Page Modern Society and Mental Disease, New York, Rinehart, 1938 Pollock, Horatio M · Mental Disease and Social Welfare. Utica, N. Y. State Hospitals Press, 1941.

discarded as more was learned about the human organism, whereas others have stood the test of time and advancing knowledge and are accepted by all psychiatrists Such is the theory of the bodily origin of the organic and toxic psychoses, which is no longer theory but established fact. In the field of the functional psychoses and neuroses psychiatry is still searching for causes, with experimentation and research going forward on many fronts, some psychological, some physical and some social Some of the better-known psychiatric theories will be discussed briefly.

Predisposing and Precipitating Causes

Most psychiatrists think of the causes of mental disorders as *predisposing* and *precipitating* or *exciting* The predisposing causes prepare the soil, so to speak, in which the accidents and the illnesses (the losses and the emotional shocks that people think of as causes) take root more easily and produce effects that they could not produce in a normal personality Heredity is a predisposing cause, as we have seen More important apparently is the "type of personality," the "constitutional endowment," the "temperamental make-up," all of which are names for approximately the same thing, which we all recognize as the differences among human beings One person is know from childhood as "queer," "peculiar," "different", another is withdrawn, seclusive, shut-in, no one can "get next to him", a third is overactive, changeable, aggressive, too excitable; still another is "just average," normal, displaying the above traits in different combinations, perhaps, but none of them to excess.

This doctrine of "constitution" is an old one, going back at least to the Greek physician Galen, and as often as it has been seemingly disproved it has bobbed up again with fresh evidence as to its veracity Twenty or more years ago Kretschmer,* confining his research to patients in a mental hospital in Bavaria, found evidence of the correlation of the functional psychoses, dementia praecox and manic-depressive psychosis with certain forms of bodily make-up The slender, narrow-chested, poorly developed body, which, as he says, is characterized by thinness in all its measurements is frequently found among dementia praecox patients The full-bodied, often large and well-developed person, inclined to put on fat as he grows older, is found among the manic-depressives if

* Kretschmer, Ernst: Physique and Character, New York, Harcourt, 1925

he develops a psychosis. Kretschmer's ideas, more or less modified, have been accepted by many psychiatrists

More recently Sheldon* and his associates have published the results of ten years' study of what they call the "constitutional pattern of the individual personality." This pattern expresses itself at both physical and psychologic levels, and they again find certain temperamental traits and qualitites correlated with certain types of physical make-up.

What this physical constitution is, how far it is inherited, how much is due to factors acting upon the child before birth, and how much to nutrition and other early environmental factors is still the object of research Few psychiatrists would deny that it is the underlying stratum of the personality The environment builds upon it and interacts with it, and thus the personality is produced.

Early Childhood Environment

The earliest years of life seem to be of greatest importance in shaping the personality The psychiatrist almost invariably finds his patients' difficulties tracing back to childhood Here we have a point of view that has been expressed many times in the course of human history and crystallized in folk-sayings· "As the twig is bent the tree is inclined" and "The child is father to the man" However, it remained for the twentieth century to grasp its full significance, yet most parents even now find it hard to realize that the earliest months and years of a child's life may be all important in starting him off on the road of normality or abnormality Psychoanalytic and psychologic studies of infants and children have multiplied within the last two decades, and the extreme importance of early family and parent-child relationships is pointed up in all of them. Through these relationships and the child's early experiences habits of thinking and feeling are formed which enable him to take life in his stride, or else cause him to meet it with evasion or temper tantrums, by building up false ideas about it, or by running away from it completely and living in his own fanciful world His constitutional make-up, in all probability, determines how he reacts to and assimilates these early experiences; he is not an entirely helpless creature at the mercy of every wind that blows.

As his body grows and develops through the food and the care

* Sheldon, W H, and S S. Stevens The Varieties of Temperament, ed 3, New York, Harpers, 1942

given it, so his personality develops in response to the attitudes of his parents or caretakers. More and more we find this point of view expressed in psychologic and psychiatric literature

Emotion

Most psychiatric theories of the present day stress the extreme importance of emotion in the development and the functioning of the personality Strecker* expresses it thus·

> The human emotions are literally the heart of the mind They are as necessary and significant to the personality for a reasonably satisfactory maintenance of mental functioning as is the physical heart to the body for the continuance of normal somatic performance. Should the heart cease to function, there is physical death, should the emotions "stop," as in profound senile and other deteriorations, then the mind dies

Emotion gives meaning to life. What we think about things is not half so important in guiding our activities as what we *feel* about them If feeling or emotion is dulled, life becomes unreal and meaningless. This idea is often expressed by certain psychotic patients who tell us they have lost their capacity for feeling and that they are therefore dead "I am walking around, but I don't feel alive Nothing has a meaning, I have no feeling about anything" Aside from the cases in which physical disease or injury acts more or less directly upon the central nervous system, the emotional factors are the most important in precipitating mental breakdown † emotional insecurity, fear, anxiety, excessive worry, and frequently the attempt to meet adult situations by following the emotional patterns of childhood and infancy The majority of mental patients are people whose emotional life has not developed to a responsible adult level, or, if it has, they have not been able to sustain themselves on that level.

PSYCHOANALYTIC THEORIES

The psychoanalysts have their own theories and explanations for personality disorders. Following Freud, they think of mental

* Strecker, Edward A . Fundamentals of Psychiatry, ed 3, Philadelphia, Lippincott, 1945, p 22

† Frequently emotional factors are also to blame in precipitating a breakdown, even in cases of organic disorders All people do not react in the same way to injury or disease There are subtle factors in the personality that seem to determine how we "take" even such things as disease and injury to the brain.

life as composed of three sections, so to speak: the *Ego*, the *Super-ego* and the *Id* The Id is the unconscious level of mental function which is all the "mind" we have at birth The *Id-impulses* are those we have in common with all other human beings, even with animals They are often spoken of as our "lower nature" or our "animal nature." They are, of course, wholly selfish, concerned only with one's own pleasure and gratification The infant knows nothing of other people and their rights and desires; he is at the mercy of his Id-impulses The Ego develops out of the Id as the go-between for the selfish Id and external reality From the very beginning, reality, in the form of parents and caretakers, imposes barriers to the full functioning of the Id The infant must learn that there are certain times and places for the taking of food, for sleep and for elimination. As he grows older he must bring the Id-impulses more and more into line with the requirements of his particular culture This task of the Ego is extremely difficult All of us slip back at times, and occasionally we see whole groups of people, as in mobs, or even in some nations of modern times, giving free rein to their lowest impulses.

The Super-Ego is better known to most people under the name of Conscience It develops out of the prohibitions, the commands and the teachings of parents and teachers At first the child is wholly dependent upon them to guide his actions; but gradually he sets up within himself standards of what to do or not to do, of what is right and wrong All of us know the tyranny of conscience It holds us back from committing antisocial acts, or it can make us miserable over trivialities. There are people whose Super-ego is essentially the same that it was in childhood, they cling to the teachings of their parents and cannot move with the times Most of us, as we grow older, discard many of the prohibitions of our childhood and do things that we formerly considered "sinful" We learn to dance, to take a social drink, to play golf or take an automobile trip on Sunday; we vote a different ticket, we join a different church and our Super-Egoes permit us to do so in peace

This, according to the psychonalaysts, is the "constitutional make-up," as we may say, of mental life In attaining his adult development the child passes through certain stages, the experiences that he meets and how he assimilates them determine his character or personality. Freud named the most important of these periods the "Edipus" stage—the period from the third to the fifth or sixth year when the child is working out his relationship to his parents

However, there are two important stages before this; how the child gets through them determines, in large measure, his reactions in the Edipus stage The first stage is the initial year of life, in which lie the beginnings of Ego formation. The child's great concern here is food-getting, and the emotional experiences that attach to food have a great deal to do with his future attitudes toward reality. The second year of life is the period of training in the control of bodily functions. This is an extremely difficult period for many children, chiefly because of unwise handling by parents The beginnings of many adult maladjustments are traced to this period, or even to the first one

Again, Freud and his followers have discovered a number of *mechanisms,** or ways in which the mind works, to enable the Ego to cope with the selfish strivings of the Id or, in other words, to enable the personality to become socialized and adapted to life in its cultural group Chief among these is *repression* It is not a conscious process, nor can it be forced, but in some way the unacceptable thoughts and feelings are buried in the Unconscious, and if repression is complete they remain there and trouble the individual no more. Often it is not complete, and the buried desires work their way out disguised as dreams, obsessive thoughts, compulsions, or in the delusions and the hallucinations of psychotics

Introjection and *Identification* are two other mechanisms of great importance in early life The child introjects its environment mentally, especially the human environment, in much the same way as it assimilates food taken into its body. *Projection* enables the personality to shift the blame for its behavior upon someone else *Defense reactions* enable it to hold certain of the Id-impulses in check and even to deny to itself that it ever had them *Sublimation* enable the Id-impulses to get satisfaction through socially approved activities There are many more of these mechanisms (all of which have probably not yet been discovered) and they have been of immense value in helping the psychiatrist to understand the behavior of his patients

What about the sexuality that is popularly supposed to be the essence of the Freudian doctrine? One who, unguided, reads psychoanalytic literature will certainly get the impression that everything is sexualized, but the Freudian concept of sex is much broader than appears at first sight It is the urge and push of life, which is everywhere concerned with reproduction. We must remember that, from

* The term *dynamism* is now frequently used in the same sense.

the biologic standpoint, the aim of development in every creature, whether plant or animal, is to reach that point of maturity where it may reproduce its kind. Nature has small regard for the individual; her concern is with the race. The life impulse always overflows and produces infinitely more than is necessary for securing its end, so that there may be no possibility of failure In man the superabundant energy of the sex impulse ramifies throughout his whole being and spreads into every department of his life, functioning in work and play, in interests and activities, as well as in his human relationships From this angle, it ought not to be difficult to understand the Freudian preoccupation with sex

It will be seen, then, that for the psychoanalysts mental illnesses and disorders have their roots in the very early years of life, when wrong attitudes toward reality are set up, and the Ego fails to deal in constructive fashion with the Id-impulses In this point of view they are confirmed by most of the psychologic studies of child development, as we have seen above

Psychoanalytic psychology is not entirely environmental, as the foregoing discussion may make it appear. The Id is the reflection in the mind of the organic constitution, and hereditary and congenital differences in the constitution will produce differences in personality Freud himself always stressed the constitutional basis of the personality However, some psychiatrists feel that the Freudian views are too one-sided, that they fail to take enough account of the present situation and of other biologic forces that may be operative in the patient's life, a defect which Karen Horney and her group have attempted to remedy. Jung is more mindful of the present situation and views the neurosis or psychosis as an attempt, however wrong or wasteful it may be, to deal with it

PSYCHOBIOLOGY

In this country one of the most influential psychiatric teachers is Adolf Meyer, who for 40 years taught psychiatry at the Johns Hopkins University School of Medicine. His system is known as *psychobiology*. It draws from all the biologic sciences and builds up a picture of the "life-reactions" in any individual case It considers mental illness in terms of "reaction types." Faulty habits of reaction, that is, of meeting life situations, repeated often enough, become fixed into patterns of behavior that are sufficiently alike in different people to be grouped into reaction-types. Psychobiology

considers an individual case in longitudinal section; beginning with heredity and the family setting, it investigates the entire life history—physical, mental, emotional and social It studies the events and the behavior of the developmental years, on through the experiences, physical and mental, of adolescence and maturity In this way, psychobiology has learned a great deal about the types of personality that suffer breakdowns and the "faulty reactions" that seem to be correlated with certain kinds of mental disorders. Different factors are given due weight, and no one "cause" can be picked out as exclusive of others Although psychobiology emphasizes the relation of psychiatry to the rest of medicine, many look upon it as giving insufficient weight to the unconscious factors.

OTHER THEORIES

If for a while psychiatry seemed in danger of forgetting the individual in its interest in his disease or disorder, there was a time, not too far behind us, when it seemed to be concerning itself wholly with the individual and neglecting the society in which he was trying to function. This has largely been corrected The *ecology* (the relation of an individual to his environment) of the psychoses is receiving increasing attention Harry Stack Sullivan and others have studied the psychology of interpersonal relationships and find disturbances in these relationships prominent in the neuroses and the psychoses. J. L Moreno has developed a theory that sees the individual primarily as one of a group (or of several groups simultaneously) and his mental breakdown as a result of a breakdown in his group relationships Anthropologic studies* of our American Indian groups, and of more primitive societies in different parts of the world, have thrown new light upon the dependence of personalities upon their cultures Psychoses take on different colors, so to speak, the abnormal ideas that persons express or put into action differ according to the beliefs and the customs of their culture The neuroses, which are so common in our civilization, are much less frequent and sometimes almost entirely absent in more primitive cultures.

We must not forget that psychiatry is also interested in the physical functions of the individual, and physical, chemical and neurologic studies of mentally ill patients are going forward all the time

* See the studies of Ruth Benedict and Margaret Mead on American Indians, and of Mead and Malinowski on primitive tribes in the South Pacific.

From this brief survey we may infer that the causes of the functional psychoses and neuroses, far from being as simple as the layman is likely to envisage—the result of heredity, of syphilis, of overwork, or of unhappy love affairs—are complex and multiple and that many of them are as yet unknown But, at least, we can feel assured that psychiatry is leaving no stone unturned in its search for causes, and out of this many-sided approach to the problem of mental disorder is bound to come a better understanding, not only of mental abnormalities but of the human personality itself and the conditions necessary for its healthful development.

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3

The Mental Hospital and Modern Methods of Treatment

What goes on behind the doors of a mental hospital is the object of great curiosity to some people and of shuddering dread to others. All patients are visualized as raving maniacs, confined in strait jackets or in padded cells. In stories and poetry the hospital is a place of doom, a house of hopelessness Employees are asked over and over if it is not a sad and depressing place, and how they can bear to work with mental patients Yet when we see the modern hospital as it really is and know something of what the majority of its patients are like and how they are cared for and treated, such ideas are seen to be much behind the times.

THE MODERN HOSPITAL

The older mental hospital, like many of our jails and almshouses today, was indeed a sad commentary on the intelligence and the humanitarian instincts of people in general Hogarth's picture, *The Rake's Progress,* which shows a mental hospital in England in the eighteenth century, gives us an idea of what even some of the better ones were like then Patients were chained to cots or benches, sanitary arrangements were nonexistent, attendants were ignorant and brutal There are still institutions in this country as well as in Europe* which fall far below the standards of the best,

* In Europe the war disrupted many humanitarian institutions Germany is said to have put to death systematically the patients considered as incurable, and as this book is written we are not yet in a position to assess the condition of hospitals and other institutions in the recently liberated countries

but such conditions as those noted above are long since gone. The modern mental hospital is not a gloomy or depressing place, and many of the indigent patients who go there find themselves in much better living conditions than they ever have known in their lives.

The mental hospital was formerly a custodial institution, in which patients were confined with little thought that anything more could be done for them than to give them physical care. Within the last half century, however, psychopathic hospitals and psychiatric wards in general hospitals have been established in increasing numbers, and the State "insane asylums" have become hospitals where research on various aspects of mental illness is carried on and many forms of treatment are employed

Most patients in our hospitals are not "raving maniacs" Some patients go through a period in which they are highly excited, tear their clothing and fight the nurses and the attendants After this period they may recover, or have a period of depression, or continue in a quieter state, though they are still not well enough to go home. Occasionally there is a case of "chronic excitement," when the patient continues for a long time very difficult to manage The majority of patients, however, are not very different, to casual observation, from any group one might encounter elsewhere They do not wear uniforms (the question is often asked), they converse or read or play games, or sit in a corner by themselves. Some sing and dance, some are overtalkative, or shout out their wrongs, or talk to voices Many assist with the work in the kitchens, or the care of the buildings and the grounds Visitors are always exclaiming that this or that person "doesn't look like a patient," and they sometimes mistake a doctor or an attendant for a patient As a matter of fact, psychiatric patients look much like anybody else The wild, staring eyes and the "sinister looks of madness" exist only in the imagination of fiction writers

There are, of course, very sick patients who look depressed or anxious, who are greatly emaciated or cannot be kept looking "tidy" Visitors are seldom permitted to see these very ill patients unless they are relatives or others who have professional interests On the whole one can see in a subway crowd or a crowd at a county fair all the varieties of bearing and of facial expression that one will find in a mental hospital

The public still believes that patients are treated by being confined in strait jackets and put into padded cells Padded cells are not in existence any place in this country that the writers know

about. Strait jackets, long garments made of stout canvas and laced with rope, in which a patient could be confined so that he could scarcely move, are mostly museum pieces now, although they were an improvement over the ropes and the chains with which patients used to be loaded. "Camisoles" are still in use in some places; they are short, stout jackets with sleeves, which are tied on the patient so that he cannot use his hands to tear his clothing or pick at his body. These are used more frequently in the institutions for the feeble-minded, where certain types of "low-grade idiots," persons who have practically no intelligence, are forever trying to tear off their clothing or pick at their bodies Such restraint is harmless, and the only alternative is a nurse in constant attendance—a very expensive proposition, often impossible to carry out.

Some patients do have to be restrained, in certain stages of their psychoses, from harming themselves or somebody else. In some hospitals they are given strong sedatives, though many psychiatrists frown upon this practice and feel that it clouds the picture so that it is more difficult to decide upon diagnosis and treatment Others use drugs that induce profound sleep. Most institutions have rooms where the patient can be isolated for a period, there he can shout, sing or bang window screens to his heart's content. Contrary to usual opinion, patients do not usually bang their heads and bruise their bodies, only in certain states of confusion, such as occur in the organic and toxic psychoses, is this likely to happen The psychiatrist recognizes these conditions, and such patients are not left alone in the "special treatment rooms" Many patients go through a period of acting like naughty little children, and about the most satisfactory treatment is to isolate them until this period is over. The modern hospital makes every effort possible to see that patients do not injure themselves or each other and that they are treated with kindness and consideration by the hospital staff As the doctor or supervisor cannot possibly watch every portion of a large building every moment, accidents may occur, and attendants may not always be kind In prosperous times—and in wartime—it is difficult to keep intelligent and properly qualified attendants They can make more money, or, as in wartime, they are urgently needed elsewhere. The efficient running of any public institution at such times becomes very difficult, and there is no question but that standards of care were, in some places, materially lowered during World War II.

In normal times patients in a mental hospital live, work and

play in as wholesome surroundings as can be provided by the taxes the public is willing to pay. The private institutions can sometimes do better, for they can command high fees The public institutions and the State hospitals of such states as Massachusetts and New York, or the Government hospital in Washington, are models of their kind and show what can be done for the care and the treatment of mental patients Each patient is treated according to the type and the severity of his illness. Work, recreation and amusement are provided as he can profit from them If he is physically ill, or needs an operation, he is cared for in a special ward, or in a medical and surgical unit, or an infirmary by special nurses and physicians As he improves, he is transferred to a building where patients are more nearly well; he may be allowed "ground parole," that is, the privilege of walking about the grounds, and be allowed visits with his family. Meanwhile he lives in cheerful quarters, attends dances, shows and movies, does his quota of work and slowly gets back into the rhythm of normal living again.

When hospitals are not what they should be, when they fail to use the psychiatric and medical knowledge that is available today in the treatment of their patients, it can be no one's fault but that of the citizenry We live in a democratic country, where each one's duty is to inform himself upon all the things that concern the public welfare If there are abuses in the public institutions, the remedy is plain: take them out of politics When a hospital position is a political plum, when tenure of office is only so long as a certain party is in power and there must be a turnover of officials every two or three years, it is obvious that the institution will seldom be run solely for the benefit of the patients, nor will the hospital personnel be the best available If we live in states where there is not an up-to-date civil service law, we, as individual citizens, are responsible for the abuses that may exist in our State institutions When it is necessary for our relatives to go there, why blame anybody but ourselves if the treatment is not what it might be?

PROCEDURES AND TREATMENT

Let us return to what happens to the patient in the good modern hospital. Whether he is brought in the police ambulance, or by public ambulance from the municipal hospital, or in the family automobile to the front door, he goes first to the admission suite in the Receiving Building, where he is met by nurses and a doctor.

The latter gives him a rapid examination that serves to discover his physical condition and the outstanding features of his mental condition. He is weighed and measured, his pulse and temperature taken, his clothing is marked; and in many hospitals, no matter how well he may be physically, he is given a bath and put to bed for 24 hours, until the physician in charge has a chance to see him and preliminary examinations can be made. He spends the first few days being looked over by the dentist, the oculist and other specialists if the physical examination has suggested that he needs them; blood tests are made and photographs taken. He may require metabolism tests, roentgenograms, a spinal puncture, heart examinations, or other tests and special examinations, for he is not just "a case of mental disorder," but a *person* who is mentally sick.

So this person, who is Mr X, is studied in every way. He is given thorough physical and mental examinations, he is encouraged to relate his own story, and his relatives or friends are asked to tell what they know of his previous disposition and behavior and his life experiences. It may be necessary, when no one is available who knows much of his history or when otherwise it is difficult to obtain, to send a hospital social worker to obtain information from employer or associates. In the case of service men, the Red Cross, through its branches all over the country, gathers the needful information. After all the studies are completed a tentative diagnosis is made, on the basis of what has been learned about him, and treatment is prescribed.

This, of course, varies with the needs and the conditions of the individual patient. Not infrequently relatives complain that a patient is "not getting any treatment, they're just keeping him there." Patients themselves often loudly proclaim the same things. The word "treatment" in connection with the physician and the hospital means to most people the giving of medicines or of some form of physical treatment like massage, physiotherapy, or electrical treatments. They do not realize that good physical care, occupation, recreation and the thousand and one things that are done to help patients back into normal attitudes toward life are treatment as truly as medicine.

As a matter of fact, no other hospital has so many types of treatment available as has the mental hospital, which can employ all the various technics developed by medicine and surgery besides many of its own. Thus, there is *hydrotherapy*, the "water treatment." A well-equipped hospital has baths of different kinds, in-

cluding the continuous bath, which is a large tub so equipped that it is continually filled with water at a certain temperature, controlled by a thermostat. The patient lies comfortably in a hammock suspended in the water, for a considerable period of time, with an attendant constantly present. Such baths are very soothing and of great benefit to certain types of patients.

Very excited or disturbed patients are placed in the so-called "cold pack", sheets wrung out of tap water (not ice water, as patients so often imagine) are wrapped closely about the body, which is then swathed in blankets. In a short time the patient begins to perspire very freely, feels drowsy, and usually sleeps

It must be remembered that psychotic persons are apt to be full of fears, delusions and misinterpretations, so they may misunderstand some things that are done for them, considering them as punishment and maltreatment. To be placed in a continuous bath may be interpreted as an attempt at drowning A cold pack may seem to be a dire form of punishment, in spite of the fact that the patient feels better afterward

Physiotherapy and electrotherapy are employed in most hospitals, limited only by the amount of money available for equipment and operators, who must be specially trained In certain forms of organic brain disease *fever therapy* is used. The patient is inoculated with malaria, and his resulting temperature rises so high that the germs which have invaded the brain are destroyed After a certain number of chills, the malaria is stopped with quinine In recent years "fever cabinets" have been devised, in which the patient is placed for a certain length of time each day By means of electrical heating, a high temperature is induced which is supposed to destroy the organisms in the same way as the malaria does

A great deal has been heard about "shock therapy" in the last ten years By the giving of insulin, a state is induced similar to the *insulin shock* of diabetic patients; the condition is then ended by giving a mixture of glucose with other ingredients After several treatments, the patient may be very much improved In other conditions, a powerful drug, metrazol, is used Injected into the veins or the muscles, it produces convulsions resembling those in epilepsy After a certain number of seizures, the drug is discontinued Improvement is occasionally apparent after a few treatments. Both these forms of shock have been largely superseded in most hospitals by *electric shock*, which also produces convulsions, but is less uncomfortable and less dangerous to the patient.

Occupational therapy is based on the theory that occupation for the hands is helpful in distracting the patient's attention from himself, in employing his creative ability and in building up his confidence. Various arts and crafts are taught: knitting, sewing, weaving, basketry, painting, modeling, woodworking, printing, and so on Often a patient can begin with only the simplest kind of work, such as tearing discarded linen into strips. As he works, he becomes more and more able to control his attention and concentrate it upon what he is making "The work of his hands" means far more than merely keeping him busy. It is a truly restorative activity His teachers have special training and have learned when to help and encourage him and when to let him alone. He progresses from one thing to another as he wishes, and as he becomes better able to mingle with other patients and to enjoy recreations and amusements, he often drops out of the "O.T" classes, they have done their work

Music, games, sports, movies, parties and dances are all a part of the equipment of the modern hospital. The day rooms, the large living rooms used by the patients, have comfortable furnishings and attractive pictures Flowers and house plants are plentiful, and books and magazines are provided All these things contribute to the treatment, and all have a part to play in helping the patient back to normality He may not appreciate them at first, nor even notice them, but as he grows better they serve to remind him of the thousand and one things in the world outside that are waiting for him when he is again able to grasp and use them

Psychotherapy is a highly specialized form of treatment which the psychiatrist employs, using different forms with various patients As its name implies, it is directed toward "curing the mind" This can sometimes be done by changing mental attitudes, by searching out buried motives, by discovering emotional sore spots, and in general by helping the patient to discover what manner of man he is and what there is in his personality that has prevented him from facing and handling his realities

Sometimes the patient needs habit training or re-education, and the therapist helps him to change his attitudes and to discover better ways of handling his interpersonal relationships He has been on the wrong track in his search for happiness or fulfilment, he must be taught to recognize his goals and to change his course toward them

At other times, the meaning of his symptoms must be explored

with him, and his whole life pattern must be reconstructed, beginning with his childhood relationships to his parents In work of this sort, some form of psychoanalysis is employed A few of the State hospitals have psychiatrists trained in psychoanalysis on their staffs, and more are found in private sanitariums. In general, the procedure of psychoanalysis is too long drawn out and expensive to be used extensively in public institutions as yet, but more and more psychiatrists are being trained in psychoanalysis and are using its technics, if not its whole procedure, with their patients. A useful aid to psychotherapy is what is variously known as *narcoanalysis, narcosynthesis* and the *sodium amytal interview,* a method devised in 1930 by Lorenz and Bleckwenn, but extensively developed during World War II By the intravenous injection of sodium amytal or sodium pentothal, a quick-acting sedative, the patient often becomes very accessible, and may relive painful experiences previously "forgotten", as a result the therapist may be able to relieve him of his conflict.

Much interest is being shown in "group psychotherapy" The psychiatrist conducts classes or discussion groups, in which the patient discovers that his case is not unique and may be encouraged to try to work out his problem with the psychiatrist, sometimes he gains enough insight from the class discussions to enable him to handle it himself. Another type of group therapy is the *psychodrama,* developed by Dr. J L Moreno. The patient is called upon to participate spontaneously in a given dramatic situation, the results often cast light upon his conflicts in a way which might only with great difficulty be attained by verbal interviews The method is thus useful both diagnostically and therapeutically.

In some hospitals, psychologists are employed who make tests and personality studies of various sorts, discover the strong and the weak points of the patient's intelligence, as well as his assets and liabilities in personality traits Much research upon various aspects of mental function and what may help or hinder it has been carried on in a few hospitals The study of intellectual function, as distinct from "level," or the amount of intelligence a person may have, has engaged the attention of others Although, as has been said several times, emotion and not intelligence is the function of the personality most affected in a psychosis or a psychoneurosis, it is often the actor hidden behind the scenes, and the disorder *seems* to be one of intelligence Memory, association, judgment, or language no longer can function properly, and psychotic behavior is the result, but intel-

ligence is not "lost" in the psychoses, nor does deterioration take place except, of course, in the organic conditions, where the brain itself is affected For years a patient may seem stupid or greatly deteriorated, but under proper stimulation he will respond with approximately the degree of intelligence that he possessed before his illness. This has been shown in various ways by psychologic tests, by recoveries after shock treatment, or by the giving of certain drugs that stimulate the patient temporarily to use his intelligence *

In most hospitals for mental cases there are "psychiatric social workers," specially trained women who smooth the way for the patient and his family when he is ready to go out on visit or to be discharged These workers know how to help the family understand the patient, to help him find employment and to take his place again in the community The social worker is a very important adjunct to the mental hospital She is the go-between for it and the community, and her grasp of social and psychologic situations and her tact in handling them go far to break down the old fears and superstitions regarding hospital treatment which is our heritage from a long past of ignorance concerning mental illness and disease.

ADMISSION AND DISCHARGE

What is the procedure in getting a patient into a hospital, and how does he get out? Are soldiers and sailors admitted in the same way?

Contrary to a widespread belief, it is much more difficult to get into the public mental hospital than it is to get out Certain types of patients talk loudly about "being railroaded into the hospital" or "shanghaied" there Ignorant friends and relatives, who may be as badly off as the patient himself, spread the story of his being kidnapped and held in the hospital. Moreover, persons who ought to know better frequently believe that people who have no business there are committed to the hospitals and kept indefinitely This would be a very foolish procedure indeed, since employees in a public hospital are not paid according to the number of patients they have, nor may they take money or gifts from relatives.

As a matter of fact, patients have to be certified by two physicians as dangerous to themselves or others before they are eligible for admission to a public mental hospital The connotation of "dan-

* Kendig, Isabelle, and Winifred V Richmond Psychological Studies in Dementia Praecox

gerous" has to be stretched considerably in order to admit very many people who would suffer severely if left in the community. The aged and indigent, without relatives to care for them, the young praecox, absorbed in his own inner experiences in a family who can neither understand nor tolerate him, the elated manic, ecstatically flying about in taxis, giving parties, running up bills and having a gorgeous time—these individuals are actually dangerous only as their lack of judgment or their inability to care for themselves may create dangerous situations. The majority of mental patients are neither assaultive nor suicidal, but they are not able to care for themselves or their affairs adequately and often involve their families or friends in difficult situations As it is, the law in many states results in leaving many actually dangerous persons in the community; relatives or some responsible person must sign a complaint, or the potential patient must do something for which he can be arrested Even when the physicians are ready to certify, relatives can refuse to have him committed In a few states a lay jury must pass upon the patient's mental status, a procedure that is about as intelligent as to have it pass upon the suitability of an appendix case for operation In our more enlightened communities, a board of psychiatrists decides whether or not a person is in need of such hospitalization

Thus, it will be seen that getting into a public hospital is a difficult problem for the civilian Once he is there, the psychiatrists have the right to decide when he is ready for discharge In practice, they usually yield to the family's insistence (if they consider it not too risky) and discharge the patient "against medical advice." Every effort is made, however, to keep him until the psychiatrists feel that he is well enough to be returned to the community He is given parole of the grounds, he makes visits, gradually extended in length, to his home, he is helped and encouraged by his social worker, to whom he or the family can always turn. As soon as he appears able to get on without the supervision of the hospital, he is discharged

If the hospital physicians consider it inadvisable to discharge him upon his own or the family's demand, he may bring *habeas corpus* proceedings and be given a court hearing as to his sanity. Unscrupulous lawyers sometimes make a practice of getting patients out of mental hospitals on *habeas corpus*, choosing, of course, those patients who have money to pay them, even if it be all the money they are ever likely to have. Occasionally the patient metes

out poetic justice to his benefactor, as in the case of the woman who believed that her dead husband had been reincarnated in a department store floorwalker and made his life miserable until she was finally committed to the hospital Here a lawyer in need of fees found her, induced her to sue out a writ of *habeas corpus,* and succeeded in getting her released by coaching her in her statements so that her actual delusions were not expressed. Thereafter, she decided that the lawyer and not the floorwalker was her reincarnated husband and proceeded to make *his* life miserable! A sadder outcome, and one that put a stop to *habeas corpus* proceedings with hospital patients in that community for some time, was that of a patient whom the psychiatrists knew to be highly delusional and very dangerous, having already killed a man whom he believed to be persecuting him. The patient was a very intelligent man and convinced judge and the jury that he had recovered from his mental illness. After several months, he began to believe that the lawyer who had handled his case was the real head of his "gang" of persecutors, waylaid him and shot and killed him.

Service men who become mentally ill are much more fortunate than civilians. Their condition is usually soon discovered, and they are hospitalized without delay on the certification of the military physicians. Before the war they were sent through receiving hospitals of the Army and the Navy, and on to the two big Government hospitals in Washington as soon as possible. Now they are sent to the various veterans' hospitals throughout the country. As a result, they are much more hopeful patients than the average civilian, for early recognition and treatment of a mental breakdown is the only guarantee that the patient will recover promptly, if recovery is possible for him.

All types of mental abnormalities used to be crowded together in the State hospitals, and in the more backward states this is still true, but in many states there are separate hospitals for epileptics and for mental defectives, the latter usually being called "training schools" There are many private schools or institutions for mental defectives, and a few for the "exceptional child," who, when he is not a mental defective, is usually a sufferer from a psychoneurotic or a prepsychotic state There are others that attempt the adjustment of the "problem" child But these schools are few and expensive. Every child psychiatrist or psychologist is confronted with numerous children who need a special type of school, but for whom none is available. The large city school system, and some others,

maintain "special classes" or "opportunity classes"; in a few places we find "twenty-four-hour day schools." Clinics and research centers are not usually custodial institutions (there are a few that are) and the child or adolescent who is so "exceptional" that he cannot be retained at home or who, as often happens, is destitute of a suitable home, must too frequently enter a training school, a mental hospital, or be sent to a correctional institution.

OTHER TYPES OF CARE FOR THE MENTALLY ILL

There are and have been other effective methods of caring for the mentally ill The *colony plan* has been in existence in various places in Europe for centuries, notably in Gheel, Belgium, where for over a thousand years the villagers have made the care of mental patients their chief occupation Patients live in cottages or private homes, under the supervision of those in charge, who are advised and directed by supervisors, who in turn are responsible to the physician Modifications of this method are in use in different parts of this country and Canada. One of these is the "foster home" or "family care" plan, in which much the same type of supervision and placement is employed as in the placement of children in foster homes. Not only is the home selected with care, but also the particular patient or patients who will fit into that home When the patient enters it he continues under hospital supervision Many patients do not take kindly to the large institution, they dislike association with so many other people and object to the regimentation necessary where so many persons must be cared for together. They have been unable to fit into their own homes, but they crave family life. Once established in a home that understands them and knows how to adapt itself to them, they are as happy as is possible for them to be Other patients who have responded well to special treatment but are not yet fully recovered can be placed in foster homes, and their further rehabilitation can be accomplished under more nearly normal conditions than is possible in the hospital Still others who can profit from foster home care are certain types of chronic patients who have settled down into a more or less childish state and for whom the hospital can do little more Under close supervision they can live happily in a family, thus releasing a hospital bed to someone who needs it more

Different forms of extramural treatment probably will increase in the future. Hospitals are overcrowded nearly every place and

unless we are to keep on building ever more and larger ones some other means of caring for mental patients must be found.

EXTRAMURAL PSYCHIATRY

How about the people who are really not sick enough to be in a hospital and yet need psychiatric treatment? It is true that many people with more or less mild mental disorders can remain in their own homes while undergoing treatment by a psychiatrist In the large cities there are psychiatrists in private practice who deal more or less exclusively with such cases. Some are attached to hospitals, outpatient departments, or clinics, though they may engage in private practice also There are those who take all types of cases, referring them to the proper institutions. Some psychiatrists are equipping their offices for electric-shock treatment and other newer forms of specialized treatment

As the public becomes better informed about the extent and the magnitude of mental illness and the necessity of undertaking treatment in its beginning phases instead of waiting till the disease becomes full-blown and effective treatment is very problematical, extramural psychiatry and methods of caring for patients outside the hospital doubtless will increase The old fear of the mental hospital as a terrible place, a relic of the days when it was truly so, is passing, and we may confidently hope that as the layman learns more about the various forms of mental illness, and especially their beginning symptoms, his fear of them as irrational states will pass also, and he will seek psychiatric help as readily as he now seeks out the doctor in physical illness.

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4

Mental Defect and the Problems That Grow Out of It

Before proceeding to a discussion of the psychoses and the psychoneuroses, we shall take up in this chapter the subject of mental defect or feeble-mindedness It is a matter about which the layman has heard a great deal in the last quarter century, owing to the development of intelligence tests and the establishment of special classes for children who cannot learn in the regular classes in the public schools World War I called emphatic attention to the subject through the application of intelligence tests to a 1 75 million of men in the armed forces, that being the first time the psychologists ever had had an opportunity to test adults in any great number As a result, articles and books were written and have continued to be written from time to time about the great numbers of mental defectives in our population and the necessity of doing something about it; consequently, the average person feels that he is better informed on this subject than on psychiatric matters in general. Unfortunately, much of his information is misinformation, which leads him to feel that the matter is much simpler than it really is and to expect entirely inadequate measures to take care of it. Mental defect is a complicated problem; it never can be settled by mental tests and "I Q." ratings alone, or by methods of treatment based wholly upon them. Mental defectives are first of all people, like the rest of us, with physical and mental assets and liabilities peculiar to their own individual make-ups. Intelligence is only one aspect of the personality, and though it is indeed an impor-

tant one, the other aspects must be taken into account in the training and the treatment of any given individual

At least some of the confusion existing in the popular mind in regard to mental defect is due to the fact that the psychiatrist has not been greatly interested in it. By definition, mental defect is a static condition, a cessation of intellectual development so far below the level of the average adult that the individual never can be expected to understand and make proper use of the more complex features of his environment Once this cessation or arrest of development has taken place, there is little to do about it from the medical standpoint, and the psychiatrist, always hoping to find cures for his patients, has largely lost interest in it To be sure, there have been great physicians, such as Itard, Seguin, Binet, and in the United States men like Walter Fernald, who have devoted their energies and in some cases their entire professional lives to the study and the care of the feeble-minded, but they are exceptions rather than the rule The recognition of mental defect as a medical and psychiatric problem, as well as a social and educational one, has not yet become general among physicians.

In mental deficiency we find the same situation as in the psychoses—that is, a group of cases in which the defect is associated with, if not always the result of, physical (organic) conditions, and another group in which no physical condition can be demonstrated to account for the defect in the intellectual sphere. We shall consider the former group first

THE PATHOLOGIC TYPES

The word "pathologic" means *diseased,* and it is a convenient way to describe that large group of mental defectives in whom physical abnormalities or physical diseases have affected the brain itself Among these the cases of birth injury are prominent, although, as we shall see, they are by no means always mental defectives

Everyone has seen cases of *spastic paralysis,* in which the limbs on one or both sides of the body are stiffened and often entirely useless Sometimes there is a degree of voluntary movement, at least the person can initiate movement but cannot control it The arms and the hands jerk about, the fingers close convulsively on an object and cannot release it; throat and mouth muscles may be affected, so that there is difficulty in swallowing food, drooling sa-

liva is common; and speech is stammering and unintelligible, or the person does not talk at all. Often in such cases there has been an injury, usually at birth, to the head, causing a hemorrhage into the motor cortex, that portion of the brain which controls movement If the damage stops there and does not extend to that part of the cerebral cortex which controls intellectual reactions, the person may be crippled physically even to a very great degree, but has, potentially at least, a normal intelligence However, the cases that are severely crippled may be cut off from so many experiences that intelligence has no chance to develop to any great extent. A child who can scarcely move a muscle voluntarily, who cannot talk, whose eyes are in such constant motion that he cannot fix them on an object long enough to perceive it clearly in detail, has a small chance of being anything but a mental defective. When the child is capable of eye fixation, it is astonishing how much he can learn if specialized methods of teaching are employed It is, of course, very difficult to examine a child of this sort and determine the degree of intelligence present No standardized tests are reliable, and the examiner must exercise all his ingenuity to get the child's co-operation and discover what his capacities are

Jimmie C, aged nine, was the eldest of four children, the others being healthy, normal youngsters. The parents, wealthy and prominent people, were anxious to do everything in their power for Jimmie, whose right side was completely paralyzed and the left partially so He could talk a little with great effort, but his speech was almost unintelligible except to the family. He had had some tutoring and could read a little, and his younger sister had taught him to recognize the digits from one to nine. Jimmie had had several examinations, or attempts at examination, and was heartily tired of the procedure, so that recently he had failed to co-operate He was usually pronounced a mental defective, but the parents were unwilling to give up The first step in the examination of Jimmie was to catch him when he felt fresh and rested after a nap. Then, by dint of stories and pictures, challenging him to a game in numbers and various other devices, he was interested and really co-operative. Jimmie was by no means feeble-minded and proved it by doing well in school work when a tutor was obtained who knew how to approach him

In recent years much work has been done with spastic children, and in some cities they are cared for in special classes, sometimes conducted in a children's hospital and again in the public schools

Teachers have helped them to better speech, and in being treated like normal children their lives become more bearable to them.

There are all degrees of birth injury In some cases the person is only slightly crippled, and in others the injury to the brain has been so great that the child can scarcely move a muscle In still other cases the injury has spread to the cerebral cortex, and there is a real mental defect. Undoubtedly there are children who would have been mental defectives even without the birth injury

Injury to the brain may occur before birth, due to some cause that usually cannot be determined, in which case there may or may not be paralysis or other physical abnormality, but there is mental defect.

Hydrocephalus (meaning "water in the head") and *microcephalus* (meaning "little head") are two other pathologic conditions in which there is practically always mental defect In hydrocephalus there is an accumulation of large amounts of the fluid normally found in the brain ventricles (cavities). The head may grow very large, but the brain itself is little more than a shell. The majority of such cases have other physical abnormalities, and most of them die in infancy If they live any length of time, it is almost always necessary to care for them in hospitals or institutions for mental defectives.

The microcephalics have peculiarly shaped skulls, and the head and the face, owing to the prominent beak-shaped nose coupled with a receding chin and forehead, are often described as "bird-like" The brain is very small, and there is corresponding mental defect These children may live to adulthood and sometimes can be taught simple occupations, but are too defective to get on without constant supervision

The condition known as *cretinism,* due to a congenital defect in the thyroid gland, is seldom found now in its most striking form, since it is the one condition in which gland treatment has been successful Untreated, the child does not develop either mentally or physically, the body is dwarfed, the skin dry and coarse, the hair scant, the teeth very late. The results of thyroid medication are startling Mary N at six years was no larger than a child of three, had neither teeth nor hair and no more intelligence than an infant of three months She received thyroid medication, and at the age of fifteen she was an attractive little girl, appearing to be about eight years old, with an abundance of dark curls, her full quota of teeth, and a mental age of six years. When treatment is begun in infancy,

the child may develop fairly normally, but treatment always must be continued throughout life.

The *Mongolian* or *Mongoloid* type of mental defect is so named because the facial features appear to resemble those of the Mongolian race. The stature is short, the head small, the face flattened and the eyes appear slanting. The intelligence is always defective; in the true mongolian it is scarcely ever above four years, though there are "Mongoloid types" in which it rises higher However, the Mongolian child is a happy, amusing, imitative little fellow, affectionate and cheerful, fond of music and rhythm; he often deceives his family for awhile into thinking he is quite bright

Georgie Q was the youngest of nine children of a professional man At five years he was brought to the psychiatrist because he was saying only a few words and could not be taught to obey. He had been the pet of the whole family, and the father thought that he merely had been badly spoiled

"He's such a mischievous little monkey," the father explained "He's always bubbling over with fun and playing sly tricks on us, but he just won't learn what we want him to " Georgie was a typical Mongolian, who at five years had the mental development of a child less than half his age.

As the mongolian grows older his retardation becomes more apparent, although he usually retains his happy disposition The majority, however, do not survive childhood; measles, pneumonia and respiratory disease in general are almost always fatal to them, few live to be thirty years of age

A considerable amount of research has been done on mongolism. The success of thyroid treatment in cretinism inspired the hope that some glandular basis for mongolism might be found, but the search has proved to be fruitless. No form of gland treatment is effective in it. Its cause still eludes us. It is not hereditary According to the most plausible theory it is due to some pathologic condition in the mother. It was noted many years ago that mongolians were frequently the youngest among a large number of children, and the conclusion was drawn that exhaustion of the reproductive function in the mother might be responsible. Recent studies* have tended to confirm this point of view and though mongolians may be the first born, or appear in almost any birth order, a disproportionately large number (matched against control groups) are followed by no fur-

* Benda, C. E , N A Dayton and R A Prouty· On the etiology and prevention of mongolism, Am J Psychiatry, 99·822, 1943.

ther pregnancies. The authors of the studies noted above believe that they have sufficient proof that a Mongolian child is born to a mother on the verge of sterility. "The maternal organism seems to be unable to produce the proper endocrine environment for the embryo." During pregnancy there is a greatly increased demand upon the glandular system of the mother. If she is approaching the menopause or is a woman in whom the endocrine system cannot meet the demands of pregnancy, either for congenital reasons or because of illness, she is on the threshold of sterility and may produce a Mongolian child Since the endocrine damage occurred while the foetus was developing, treatment after birth cannot undo it, therefore, the mongolian does not respond to endocrine therapy, or gland treatment Whether or not this is the true explanation, the cause of mongolism remains a medical question, and we must wait for medical research to give us the answer

There are other cases of *mental defect associated with prenatal disease or injury or with diseases occurring in infancy or early childhood.* The cases of congenital syphilis are often defective, though by no means invariably so The acute diseases of infancy and early childhood in which there is a high fever with unconsciousness, delirium and convulsions, implying an inflammatory process in the brain, are frequently followed by mental defect of greater or lesser degree Influenza, pneumonia, measles and whooping cough may result in brain injury and consequent lack of development; recent studies have indicated that whooping cough in infancy is a fairly frequent cause of mental defect Fortunately, infants can now be immunized against it.

CONGENITAL FEEBLE-MINDEDNESS

In the majority of cases, however, no physical cause can be demonstrated for the mental backwardness Intelligence merely develops slowly and never reaches the average level The child is a *congenital defective,* born without the potentiality for normal intellectual development.

"Isn't heredity responsible for this latter group?" the layman asks. This applies only in a certain percentage of cases Hereditary mental defect accounts, certainly, for the majority of cases in our public institutions Defective parents cannot rear their children properly, and they are often so neglected or abused that the State must perforce step in and take care of them However, there are

numerous private institutions for defectives, usually known as "schools"; and parents who have the means employ tutors, governeses, or companions for their children who, if they had been born into another stratum of society, would have had no recourse except to a public institution The fact that people have wealth, high social position, normal or even brilliant intelligence is no guarantee that they will not have a defective child. Let us recall the carriers of defect mentioned in Chapter 2. When two normal people each carrying genes that are defective in the same particulars beget children, one or more of the children may be defective. In this case heredity is responsible, though it may not appear to be.

Some students of mental defect believe that unnoticed birth injuries or injuries that occur before birth account for the congenital defective, but no theory is as yet accepted by all authorities.

CLASSIFICATION OF MENTAL DEFECTIVES

In this country, mental defectives as a group are frequently referred to as the feeble-minded and are classified into *idiots, imbeciles,* and *morons.* In England, instead of the term "moron" (which means simply "dull"), the term "feeble-minded" is used The idiot does not develop beyond the mental age of three, as measured by widely used tests, and the imbecile not beyond seven. The idiot does not learn to talk, though he sometimes can say a few words or pharses The imbecile does not learn to read except occasionally, with very special teaching The moron never reaches adolescence mentally. His educational limit is the fourth grade, though owing to his good memory and to our American habit of pushing children on through the grades to let them get what they can, he more or less frequently is found in higher grades.

Idiots are usually found among the pathologic cases described above. Idiocy implies a great defect in the brain, whatever the cause. The "low-grade" idiot's intelligence is almost zero, and fortunately such cases seldom live long. When the child has a physical condition such as we have noted above, it is easier for the parents to accept the fact that his intelligence will not develop. When, as occasionally happens, he is well-formed physically and seems to develop normally, it is difficult for parents to believe that he never will develop out of infancy mentally, even though he may grow to manhood physically Usually not until he is nine or ten months old and does not sit up or respond to his surroundings with interest and

comprehension, do the parents begin to wonder about him. As he grows older they are likely to drag him from one doctor to another and try all sorts of "treatment" in the vain hope that something can be done Such a child may have illusory gleams of intelligence that keep hope alive.

"He is so smart in some ways," the mother will say. "He loves music, and he has a good sense of rhythm He seems to understand lots of things—if he would only talk he would be all right" But the things he does are normal to early stages of infancy, and he must be judged in relation to what belongs to his age.

Idiots differ in what we usually call personality Some are placid and good natured, others irritable, excitable and very difficult to care for. The extent and the type of damage to the brain is probably responsible for their behavior.

Imbeciles differ from idiots only in degree Commonly they also have physical defects of one kind or another, and in most cases are poor biologic specimens Here again the parent is prone to believe that the child is all right except for his physical handicaps, but the psychiatrist regards both the physical and the intellectual deficiencies as expressions of the same fundamental defect and so far has been unable to reach it. Again, the imbecile sometimes has a good body and may be good looking or attractive in a childish sort of way He merely develops very slowly, and even when an adult is unable to "learn to manage himself or his affairs," to quote the English definition. He cannot learn in school and can be taught only very simple tasks Imbeciles are alike only in their low intellectual status, they differ markedly in personality Some are good natured, apathetic and indifferent, others are sensitive, high-strung, easily angered, or "nervous" and excitable

Idiots are practically always unable to reproduce, but not so the imbecile, especially the higher-grade imbecile This makes it imperative that the girls especially be carefully supervised Left to themselves, neither boys nor girls appear to have much sex drive and are seldom aggressors, except in a childish fashion, but their poor intelligence and lack of normal inhibitions make them easy victims of the unscrupulous and the somewhat brighter. However, once having been initiated into sex practices, an imbecile boy may become a menace to younger boys or to little girls Likewise, it is not at all uncommon for an imbecile girl of poor social and economic status, often from a defective family, to produce a number of illegitimate children, to become wards of the State.

However, it is neither idiots nor imbeciles about whom we hear most, who are in reality the real problem among mental defectives Because of their greater number and because we are as yet unable to provide adequately for their care and training, it is the *high-grade feeble-minded* or *morons* who constitute the gravest problem. Some of these people are poor physical specimens, and their defect is part of their poor biologic equipment Many others, however, have good bodies, and the lack appears only in the intellectual sphere.

We must remember that intelligence makes no leaps. It shades from the poorly equipped on through the average and up to the superior and the genius The moron stands so far below the average that he really has no business in an adult world Yet there is a still larger group who possess "borderline" intelligence, whose members may grow into useful citizens with proper training The difference between the moron and the borderline groups consists not always so much in the amount of intelligence possessed as in the ability to use it Two men may have exactly the same amount or level of intelligence as measured by the best tests we have, yet one be definitely feeble-minded and the other considered as normal by everyone Again, we have the difference in personality traits, which makes one person industrious, teachable and peaceable and the other lazy, irresponsible and unwilling to learn

James H and James N were two boys of the same mental age, around eleven years James H was a whining, childish fellow, who refused to go to school and became involved in trouble at an early age His doting mother shielded and protected him, refusing to have him sent to an institution until he had stolen an automobile and wrecked it in trying to drive it. James N came from a stable, hard-working family, who set him to work as a plumber's helper as soon as he left school, having by much hard work and help from his older sister finished the sixth grade He recently served in the Army for two years

It is natural to think of the moron or the feeble-minded as dull and stupid, and a jury confronted with a good-looking, alert person with a good memory is often not inclined to take the word of the psychiatrist or the psychologist that this person is a mental defective.

May Ann, a bright and exceedingly pretty girl of seventeen, who answered promptly, if not always accurately, and could recite long poems from memory, was unanimously declared "of sound mind" by the jury and sent to prison for participating in a robbery that

had been planned by two brighter companions. In prison she behaved like the child she really was, fighting, breaking up furniture and threatening to kill the superintendent. The prison authorities considered her insane and sent her to a mental hospital, where some of the psychiatrists, seeing her in conference, again doubted her low mental status However, a residence of two years in the hospital, where she displayed a few temper tantrums but otherwise behaved fairly well when treated as a child, served to convince everybody that she was incapable of understanding and adapting herself to the standards and the requirements of the adult world. Her subsequent career has proved that the diagnosis was correct.

INTELLIGENCE TESTS

Intelligence tests originated in France about forty years ago, with Dr Alfred Binet. He compared the school children of Paris with one another as to their knowledge of certain facts and their ability to do certain things, such as copying a diamond-shaped drawing, discrimination of weight differences among small blocks, or reproducing a design from memory Since the children all came from the same general environment and presumably had been exposed to much the same experiences, he reasoned that differences in ability would indicate differences in learning capacity or "intelligence" By trying out a large number of tests and selecting those which the majority of children at each age level from three to twelve (later extended to fifteen) were able to do, he built a scale which has been the model for most intelligence tests since constructed

In this country especially, there have been numerous revisions and extensions of the Binet scale The ones in most general use now extend the tests to adult levels. average, superior and very superior There are also "point scales" and scales of various other types, but the Binet revisions have by far the widest use The terms *mental age* and *I Q.* have become familiar to nearly everyone, though their meaning is not always explained. The mental age represents the child's successes on the scale He may be twelve years old and pass only enough tests to give him a mental age of ten years Thus he is considered as two years retarded The I Q is calculated by dividing the mental age by the chronologic or life age and multiplying by 100, with certain corrections necessitated by the fact that development slows down in adolescence, and the adult level is reached presumably at about the age of fifteen. That is, in computing the

intelligence quotient for an adult, the chronologic age is assumed to be fifteen

Rightly used, intelligence tests are of great value in studying a person's abilities and the use he is able to make of them in test situations. On the other hand, the wholesale giving of tests, often by persons who know little of psychology and must carry them through in a wholly mechanical manner, and the classification of children as bright or dull or feeble-minded on the basis of I.Q.'s or test ratings alone is regarded by the psychiatrist as a vicious practice. There are many facets of intelligence, and many factors enter into its function Besides, the psychiatrist is interested in the whole personality The physical condition, the family and the environmental history, the developmental history, the temperamental and emotional make-up and a number of other things must be taken into consideration in making a diagnosis, and, we may add, they should be taken into consideration also in interpreting an intelligence rating

When intelligence tests standardized on one population, such as white children in a school environment, are applied to other groups, such as Negro children, or Indians, or white children in a very different environment, the results are seldom reliable, although such studies have been widely publicized and inferences drawn as to the presumably lower mental level of Negro and Indian children. There are almost insuperable difficulties in applying such tests to children of another cultural group The same is true to a large extent in applying to adults tests standardized on children They must be changed and adapted and often interpreted in a fashion regarded by many psychologists as rendering the results entirely unreliable, though others consider that by the use of tests in this way they learn what they wish to know about the subject Fortunately, we now have tests designed for and standardized upon adults

Psychologists themselves are the sternest critics of intelligence tests, constantly revising them and trying to find new methods of estimating intelligence, so that in the near future we may expect far better methods of classification and diagnosis of children's learning difficulties than we have at present.

CONDITIONS THAT SIMULATE MENTAL DEFECT

We must not lose sight of the fact that there are *conditions that simulate mental defect.* We have long known that the deaf child

may appear dull without being so, and that the child with eye defects may appear stupid in school, but it is usually taught that physical conditions have little effect upon intelligence. Probably, except for conditions affecting the brain itself, they have no effect upon the level or the actual amount of intelligence, but they may have a great effect upon its function. The child with tuberculosis or heart disease, or with a debilitating disease like hookworm, cannot use his intelligence with the ease and the facility that the well child can, and may appear stupid when he is really sick.

Further, we now know that many children who have been unable to progress in school are cases of reading and language disability rather than of mental defect. The number of poor readers is amazing. A survey a few years ago showed the average reading ability in this country to be sixth grade Many college students could do no better There are various causes for the inability to learn to read or to read fluently, which need not be given here In many school systems when a child has difficulty learning to read he is given special examinations to locate the cause of the difficulty and special teaching to help him overcome it, but in many others he is considered as a mental defective and little is done for him. Reading clinics are maintained by a number of colleges and schools, and as the public becomes aware, not only of their services to children but to adults who are handicapped by poor reading ability, their number probably will increase

Of all the causes of simulated mental defect, the one most frequently overlooked is the emotional one The anxious, nervous, timid child cannot bring his energies to bear upon school work or upon the usual adaptations to environment The child who is the victim of fear or apprehends the world as hostile may withdraw within himself and shut out the unfriendly reality to such an extent that he appears to be defective, even in a profound degree A number of cases have been reported in which seemingly defective children have proved to be normal when the energy tied up in emotion was released.

We have seen one child who at three was diagnosed as an idiot because of his behavior (he would not co-operate on tests) develop into a normally intelligent young man, although he has needed help from time to time with his emotional difficulties Another child who was seen at eighteen months appeared to be very defective, being at least nine months retarded according to the usual tests. He was taken in charge by a woman who had been very successful with dif-

ficult children; in two years he had advanced sufficiently to take his place in nursery school Cases like these show the necessity of something more than an intelligence test in the diagnosis of mental defect.

A person suffering from certain forms of mental illness may appear defective to the layman, and not infrequently to the psychiatrist as well, until special studies are made This is especially true of certain types of dementia praecox and of depressions Young praecoxes may appear dull and be unable to learn in school, although they may be able to do much better on intelligence tests than their school placement lends one to expect On the other hand, the depressed person who is in touch with reality and to casual observation may appear to be fairly normal in intelligence may, even on repeated examination, give an intelligence performance far below what he is capable of when he recovers *

We may sum up this discussion thus far by repeating that mental defect is not a simple matter Its causes are various, and only a certain number of cases belong to the strictly hereditary group. It may be complicated by personality defects or by the development of neurotic or psychotic manifestations The old idea that "you have to have brains to go crazy" is not true People of any level of intelligence except the very lowest develop psychoses Intelligence tests are very useful as an aid to study and diagnosis, but in themselves they cannot give us the final word. Always they must be interpreted, and one must ask, "Why does this person grade at a defective level?" Many conditions may simulate mental defect, and a differential diagnosis between mental defect and some other mental or personality disorder may involve considerable study and observation Mental defect is a medical, a social and an educational problem, but first of all it is a medical one Once the diagnosis has been made by a competent authority, we may turn our attention to the other aspects and consider training and management.

TRAINING THE MENTAL DEFECTIVE

One is often asked, "Can't training in a special school or under a psychologist normalize a mentally defective child?" The answer can only be no, if the child is actually feeble-minded. As has been said above, special training can do a great deal for the borderline

* Dr Richmond has reported a number of such cases elsewhere See *The Adolescent Boy*, New York, Rinehart, 1933, Chap 3, also Chap 15 in this book

case, enabling the patient to function on a comparatively normal level. It can enable the moron to develop skills and abilities which otherwise would have remained latent. The high-grade moron is often capable of good manual work and can operate machines, he may enjoy music and even learn to play an instrument; but he is not capable of planning or of creative work His intelligence cannot be developed above a certain level, and attempts to train him beyond his ability result only in "nervousness" or rebellion and the development of poor personality traits. So far as our present knowledge extends, the limits of intellectual development are fixed for each of us, although probably few people develop up to the limit of their capacities.

When should a child be sent to an institution; or, to put it another way, what kind of child can be kept at home? The answer to this question depends upon both the personality of the child and the ability of the home to care for it. In general, institutions do not like to receive children below school age, up to that time most of them can be cared for at home Some private institutions take children earlier if they consider them to be trainable. Idiots and low-grade imbeciles are nearly always better off in institutions and should be placed there as soon as the institution will take them. Aside from the fact that it is difficult to care for an idiot child, his presence in a family of normal children almost invariably works a hardship upon his brothers and sisters Parents often must be told that the time and the money they are spending upon the defective child can bring them no return and should be transferred to the normal ones. The psychiatrist or the psychiatrically trained psychologist seldom errs in the diagnosis of idiocy or low-grade defect, and once the diagnosis has been made it is well to accept it and plan for the child's future on that basis.

The higher grade imbecile, who may reach a mental development of six or seven years by the time he is an adult, if he is the placid and docile type, may safely be kept at home as long as there is someone to be responsible for him, here, again, we must regard the attitude of the other children toward him, as well as the circumstances of the home. Lucy N , aged eighteen and the youngest of ten children, was brought to the psychologist by her mother and a married sister, the latter being very insistent that the girl should be institutionalized However, Lucy was a good-looking young woman with a happy disposition and a mental development between six and seven years. She had been well trained by her mother; she

could do much of the housework and sewed and embroidered a little. She was her mother's constant companion and a great comfort to her. The mother wished to keep the girl with her, there being no other children left at home, and since she could give ample supervision there appeared to be no reason for her institutionalization at that time.

When the imbecile child is growing up with normal brothers and sisters, the situation is different Often he takes too much of the mother's time and attention and becomes a source of irritation and embarrassment to the others, especially if he is irritable, excitable and aggressive, as often happens. In such cases the child and the family are better off if he goes to a good institution

The chief difficulty arises with the moron child, whose real mental status may not be evident to the parents until he starts to school When the parents themselves are not very intelligent, or are defective, they cannot be expected to realize the child's defect Even intelligent parents may delude themselves into thinking that the child is merely developing slowly, or that he is retarded because of feeding difficulties, an accident or illness, or some other unfavorable circumstance. Retardation does arise on these bases, and, as we have seen, it is likely to be very severe The moron child develops slowly, though sometimes his motor development is not far outside the normal limits, and the parents do not consider him greatly retarded in crawling or walking He is late in talking and in learning to protect himself against the ordinary hazards of the environment. He may be alert and have a spurious brightness, and it is hard to realize that he is actually defective Even the ordinary mental tests may be inconclusive. However, the congenital defective can nearly always be recognized within the first year of life if modern methods of developmental diagnosis can be employed by the physician and the psychologist

The moron is most in need of early diagnosis, since his future happiness and usefulness depend upon beginning his training early. The child who enters school only to fail to learn, or to learn very slowly and to fail of promotion or be sent to a special class, is likely to develop feelings of inferiority and bad mental habits which will stand in the way of his further training. However, the public institutions and the State training schools almost invariably have a long waiting list and can take only those most in need of their care. Therefore, they are likely to admit only those morons who are destitute of suitable homes or whose personalities are such that they are

a menace to others The "good" moron—good natured, docile and obedient—is likely to attract little attention and to be left at home, where he may get along very well so long as the parent is able to protect him. Hence he often does not learn as much as he is capable of and as he grows older, if not constantly supervised, his very good nature is likely to get him into trouble.

It is not often possible or desirable to place this type of moron in an institution, he needs the security of a home perhaps more than the normal child, and the number of cases is so great that, in any event, he cannot always be institutionalized He needs training within the public school system along the line of the abilities he does possess, since he is capable of self-support, and if properly trained from early childhood into good habits he is far more likely to retain them than are his brighter brothers In some of the private institutions excellent work is done, not only with the "good" types but with unstable and neurotic children who are poorly endowed mentally. The results with some very difficult cases put to shame our ordinary methods of training and our expectations in work with morons The same is true in a few public institutions, but here the large populations, inadequate funds and, too often, political pressure prevent many of them from doing what might be done to ease the burden of mental defect upon the community

The moron is often involved in crime and delinquency, often being only the stooge or the agent for brighter criminals Alcoholism and vagrancy are frequently associated with mental defect, as also is prostitution Personal unhappiness and failure at social adaptation nearly always occur when the moron is left unsupervised in the community.

We may conclude, then, that the problem of mental defect is, in its larger aspects, a community problem In its social and economic aspects it directly affects the community as, of course, all psychiatric conditions do; but uncomplicated mental defect is much more amenable to training and management than the neuroses and the psychoses—at least in our present state of knowledge. There is much experience and precedent to guide us in our dealings with it and much expert knowledge waiting to be used Not until the layman stops thinking that his duty is done when he has paid his taxes and really informs himself upon the subject, whether he has any personal interest in it or not, may we expect intelligent attempts at a solution of this problem

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5

Psychoses Associated with Organic Conditions

In an earlier chapter reference was made to the fact that certain forms of mental disorder are closely linked with damage to the brain tissue. The layman has no difficulty in grasping this concept, indeed, even many physicians are inclined, from their long practice in looking for physical causes, to assume that there must always be a physical cause for a mental disease. We have seen that in the majority of cases this cannot be proved. However, in the brain we find certain functions localized The perceptions of the organs of special sense, such as sight and hearing, are recorded in the brain; memory, so far as we know, is a function of the brain; the brain is the associating organ, as well as the organ that is essential to movements of the body and, indeed, to life itself. It is not strange, therefore, that where we find damage to the brain tissue we are likely to find some disorder, at least, of that complicated thing which we call personality and of its functioning.

However, the great danger is that although the layman understands the fact that brain damage may bring about mental symptoms, the results are not always so dramatic as those that follow, let us say, a skull fracture They may be insidious in onset, so that the early symptoms may be overlooked by those in close touch with the patient, and treatment at a crucial stage may not be instituted Once a nerve cell is dead it is not brought to life nor is it replaced Some types of brain damage are not reversible—that is, the results

are permanent. There are other conditions, of course, in which toxic effects are brought about, as, for instance, by alcohol, that may be transitory. In the delirium of fever, for example, the patient may be seriously disordered for a short period and yet in a few days be mentally clear again. These conditions, which are associated with infections and with intoxications, will be discussed in later chapters In this chapter we shall consider the types of mental disorder that are associated with *dementing* processes—that is, in which there is lasting impairment of the ability to remember and to think

Characteristic of this entire group, which may be referred to as the *organic dementias,* is a deterioration of the personality There are noticeable defects in memory and in judgment, there is emotional instability, and there tends to be a deterioration of the finer feelings as well The whole personality changes, it is not merely that a defect of memory exists, even though that is one of the outstanding features in all of the organic dementias.

GENERAL PARESIS

Next in frequency to the dementias occurring during the senium, or period of old age, is the mental disease due to syphilis of the central nervous system known as general paresis Syphilis is still a very common disease, although fortunately it has at last been brought out into the light of day so that it may be discussed intelligently and freely. As a result of the campaign of education that began during World War I and has been vigorously prosecuted by the present Surgeon General of the United States Public Health Service, Dr Thomas Parran, great progress has been brought about, not only in methods of treatment, but in the readiness of those acquiring the disease to accept treatment early and to continue it consistently As a result, patients suffering from general paresis are now admitted to the hospitals at an earlier stage in the development of the disease than was formerly the case, and the number of cases is decreasing

It should be pointed out that general paresis usually appears ten years or more after the initial infection, that it occurs in probably not much more than two per cent of all the persons who have syphilis, and that the likelihood of its occurring in a person who has been treated early, vigorously and consistently is greatly reduced Fortunately, too, great progress has been made in the treatment of this particular form of syphilis Twenty-five years ago no known

treatment had any noticeable effect upon the course of the disease, and death usually followed in convulsions within three years after admission to hospital. In 1917 an Austrian psychiatrist, Dr Wagner-Jauregg, demonstrated that high fever had a beneficial effect upon the patient suffering from paresis, and in 1922 this treatment was first used in the United States at St. Elizabeths Hospital, under the superintendency of Dr William A White Malaria was the form of fever-giving disease utilized, and that practice has continued to demonstrate its value through the years. Other forms of fever therapy, such as the fever cabinet, have proved to be of value The sooner the treatment is undertaken after the onset of the mental symptoms, the more likely is the cure, even though the disease process usually can be stopped, if much damage has been done to the tissues of the brain it cannot be repaired, with the result that the patient's mentality will remain more or less damaged even though he is no longer "actively paretic." The condition, then, although considered hopeless twenty-five years ago, is now fairly readily amenable to treatment, particularly in its early stages

What are the early signs? First of all, it should be said that the patient may not know that he has syphilis This is true of many adults, the disease can be contracted without the knowledge of the person who has it The earliest symptoms of paresis that can be demonstrated are usually at the neurologic level—that is, they can be detected by the physician before any perceptible change in personality is observable. One of the first symptoms of which the patient may complain is a slight forgetfulness, a rather easy fatigue, both physical and mental He may consult his physician, and a careful physical examination may indicate the characteristic neurologic changes in the pupils of the eyes, in the fine musculature of the face, the lips, the tongue, and in the deep reflexes Sometimes, too, difficulties in gait are observable, particularly when walking in the dark, when what is known as the muscle sense shows its deficiency Among other early signs are found a tendency to omit syllables in speech or writing, a characteristic speech defect, tremulousness of the fingers and the fine muscles about the mouth, together with progressive forgetfulness and a carelessness in dress and in speech, and an impairment of judgment The patient may exhibit restlessness, alcoholic overindulgence, a tendency to irritability, or such well-being and elation that he may engage in rash business deals and lose money as a result. These symptoms, if nothing is done about them, will tend to progress, and as the feeling of well-being

increases, the difficulty of inducing the patient to see a physician increases also. Sometimes, indeed, these symptoms are so grossly overlooked by those about the patient that nothing is done until suddenly a convulsive attack supervenes. This is usually enough to jolt the family into action, although its incidence means that a rather marked development of the disease has already taken place and that treatment is late. As the disease progresses there is a tendency for the patient to put on weight, to become more and more demented and silly, and sometimes very exaggerated ideas of greatness develop He may insist, for example, that he has millions or billions of dollars, that he is the ruler of the universe, that he is the strongest man alive, even though at that very time his muscular weakness and his in-co-ordination have resulted in his being practically bedridden.

At the present time about 7 per cent of the first admissions to mental hospitals suffer from this form of mental disorder. Thus it would seem to be a serious thing numerically as well as socially and economically There is a juvenile form of paresis, due to congenital syphilis, which will be discussed in a later chapter

Sometimes relatives refuse to accept the diagnosis, or to have the patient committed to a hospital too late Mr H K, a man of forty, who had a small but successful business in leather goods in a large Eastern city, began gradually to neglect his business, to talk interminably to customers and to resent his wife's reproaches for his changed conduct A psychiatrist who had been his customer for several years entered the shop one day and suspected from his rambling and elated speech and the unaccustomed disorder and confusion of his stock that an organic change of some sort was imminent. He induced the family to send him to the Municipal Hospital, where a spinal puncture was taken and the diagnosis made The man's brothers, however, were outraged, and refused to believe the doctors "No such condition had ever existed in the family," they declared They removed him from the hospital and sent him to a sanitarium run by a religious sect, where he was treated by baths, diet, the reading of prayers and religious exercises Not until he began to have convulsions and the sanitarium refused to keep him any longer was he taken to a hospital and given malaria He was very ill physically for some time, but finally improved to some extent, but was the mere shell of his former self and became a permanent hospital resident

There are other forms of involvement of the central nervous sys-

tem by syphilitic infection. The differential diagnosis calls for medical attention, and most of the other forms are likewise reasonably amenable to treatment, if taken in time.

EPIDEMIC ENCEPHALITIS

Another illustration of the manner in which a generalized infection of the brain tissue may alter the entire personality is found in the condition correctly termed *epidemic encephalitis,* but colloquially referred to as "sleeping sickness." This condition, an inflammation of the brain tissue which was quite common during the early 1920's but is fortunately much less so at the present time, was apparently a new disease due to virus In the acute phase there is a low-grade fever, with drowsiness and stupor, symptoms that have given the name to the disease The late effects, however, are of particular interest to the psychiatrist. As one would expect in a growing and developing organism, these changes are more striking in children. In very young children encephalitis may result in a permanent failure of development—that is, mental deficiency. In somewhat older children, although the intellectual impairment may not be noticeable, there is often a considerable disorder of the personality * In adults it is frequently found that some little time after the infection a slowly developing condition resembling "shaking palsy" (*paralysis agitans*), or Parkinson's disease, develops In this condition the speech becomes drawling and indistinct, the face grows rigid and masklike, there is a general stiffness of the muscles, a tendency in walking to carry the center of gravity progressively forward, so that the patient appears to be running in order to catch up with his body. In addition, tremors of the "pill-rolling" variety are common. The masklike expression of the face makes the patient appear more stupid than he really is As a matter of fact, the intelligence in an adult is little affected. There may be instability and suspiciousness as defense against the feeling of conspicuousness. Unfortunately, the patient recognizes his physical disabilities and may become difficult to care for at home. The muscular stiffness and the tremors tend to increase, and so far only palliative treatment—that is, treatment which has its effect only while the drug is being administered—has been discovered The condition is not in itself fatal, but the course is long and progressive.

* For further discussion of childhood encephalitis, see Chap. 15, "Psychiatric Conditions in Children."

INFANTILE PARALYSIS

It should not be thought that every infection of the nervous system necessarily affects directly the functioning of the personality. *Anterior poliomyelitis,* or infantile paralysis, is a sample of this type of infection In this disease the damage done is almost exclusively to the motor nerves in certain parts of the spinal column, so that the disease process in the first place is located below the level of the brain In those instances in which the infection attacks the brain tissue, death is likely to result promptly Everyone knows of someone who has suffered from this disease, a condition that is sometimes very crippling, and little can be done for it Most persons show an extraordinary courage in dealing with their situation, and by this time it should be common knowledge that such persons, far from being mentally impaired, are frequently brilliant The psychiatric interest of infantile paralysis, except for the remarkable ability that its victims show in compensating and overcoming their physical deficiencies, is nil.

ESSENTIAL HYPERTENSION AND ARTERIOSCLEROSIS

We have spoken of the ways in which infections may attack the brain. There are other forms of damage to which this important organ is subject, and one of these is due to interference in nutrition by reason of impairment of the blood supply. In the condition of high blood pressure, known as *essential hypertension,* there may occur a spasm of the vessels which causes temporary loss of consciousness, mental confusion, or convulsions These attacks are usually relatively brief, and recovery from the individual attack is apt to be reasonably prompt, but with repeated attacks a certain amount of mental impairment may become noticeable.

In later middle life changes in the blood vessels may take place which are usually referred to as *arteriosclerosis*—that is, hardening of the arteries Here we find a thickening of the walls and a narrowing of the openings in the blood vessels, so that it is more and more difficult for the blood to flow freely through them; and sometimes there is an actual deposit of calcium in the walls of the arteries. Not uncommon is the rupture of one of the small arteries in the brain, resulting in what is known as *apoplexy.* Instead of this, the opening may become gradually smaller until a *thrombosis* occurs—that is, a formation of a clot within the vessel. In the earlier

stages preceding the apoplexy or thrombosis, attacks may occur similar to those described under hypertension, together with irritability, emotional instability, worry over the condition, headaches, easy fatigue and inability to concentrate on the work at hand When a thrombosis or hemorrhage occurs the patient usually experiences a sudden loss of consciousness, frequently accompanied by a paralysis of the half of the body opposite to the side in which the hemorrhage has occurred In right-sided *hemiplegia,* as such paralysis is known, speech may be affected so that the patient cannot call familiar objects by their proper names, he may know a watch, a knife, and so on, may use them properly, but cannot say, "That is a watch," or "a knife " This condition is known as *aphasia.* Memory loss and a general tendency to mental deterioration are common The degree of the damage to the patient's ability to get along with others is apparently more dependent upon his previous soundness of organization and his balance than upon the degree of actual damage to the brain

However, many people with cerebral arteriosclerosis go on for years without attacks that are recognized, although a gradually developing change of personality is evident to those about them They become irritable, forgetful, careless about their work and personal appearance, or develop explosive tempers When such a person is in a position of authority in business or industry, or even as a parent in the home, there may be a difficult time for all concerned, especially as a physical examination may not show definitely what is the matter. Even when the person knows that he has high blood pressure and has been warned by the doctor to avoid excitement or strain, he may not be able to do so, indeed, the sufferers from this condition are not likely to have very good judgment about themselves.

Miss E. J. was a supervisor in a bureau in a Government department, a woman respected by everyone who had known her in earlier life, but for a number of years she had been very difficult to work with She was always giving orders and then rescinding them, or scolding her subordinates for carrying them out. She planned impossible amounts of work and was greatly upset if they were not done, often making the employees under her work over time She flew off the handle frequently, lecturing and scolding; she could not keep track of work done, and anything outside the routine angered her and led to more lecturing The newer people in the bureau were very unhappy, and transfers were frequently requested Her friends felt that something was wrong, but she steadfastly re-

fused to see a doctor, saying that she felt perfectly well Then one morning while dressing she fell in the bathroom and struck her head against the tub When found she was confused, her speech was indistinct, and she was unable to recall anything that had happened In the hospital she gradually improved, but never was able to return to work She believed, and so did her family, that her condition was due to the blow on her head, but the hospital diagnosis was cerebral arteriosclerosis.

Alvarez* believes that "small strokes" are common in older people, and because they rarely cause noticeable symptoms such as paralysis or speech defects but do cause nausea, vomiting, dizziness and abdominal symptoms they are not recognized for what they are and the patient goes to a gastro-enterologist, or "stomach specialist," and is treated for acute indigestion In such cases the usual signs of hypertension may not be present. Characteristic of this type of disease is its quick onset The person suddenly seems to become "ill and discouraged, miserable, apathetic, depressed and unable to work" No matter how much treatment the patient receives for this or that, the personality change is likely to persist A good history will nearly always disclose a period, perhaps brief, of nausea, dizziness, pain in the head, a feeling as though something were wrong with the heart and a sudden forgetfulness These symptoms occur in many other conditions and are not significant unless they are followed by the persistent change in personality Such persons are not likely to consult the psychiatrist, and the physician, either because he does not get the history or because his training has not taught him what to look for, may not be alert to the symptoms of mental disorder

If the trouble is recognized, such persons can be saved, says Alvarez,

> from much useless and misdirected treatment and much harassment at the hands of solicitous and outraged friends and relatives Often business associates should be appraised of the fact that the man's career is ended, and that it will be costly to the company to leave him longer on the job Often such a man proceeds to ruin his own fortune through unwise investments and expenditures Usually members of the family keep exhorting the victim "to snap out of it," to quit his "foolishness" and go back to work, but in almost every case of this type the damage is irreparable, and little if any improvement can be expected . Many of these persons live on for from five to fifteen years, but as time passes they tend to get more of the little shocks, each one of which does further damage to the brain

* Alvarez, Walter C Nervousness, Indigestion and Pain, New York, Hoeber, 1943, pp. 252ff

Occasionally it happens that in a case of this sort there is little or no loss of interests, and sometimes the failure in health is not particularly noticeable. "Indeed, there are some instances in which one wonders whether or not the general physical picture is much changed at all." Alverez cites the case of Pasteur, who suffered such "little shock," but continued to do good work, and mentions also a man of seventy whom he knew, "who, after three small strokes severe enough to fell him to the ground, recovered and lived on in good health for another ten years "

TREATMENT IN ARTERIOSCLEROSIS

The treatment of cerebral arteriosclerosis is not particularly satisfactory In such cases as those discussed in the preceding section, which are fairly frequent, patience and understanding on the part of the family and removal of stress and strain from the sufferer are perhaps all that can be done. In the more obvious cases it is easy to overdo the amount of attention given the patient with the result that he thinks of himself as an invalid and concentrates more upon his disabilities than is good for his mental health The paralysis and the speech defect often show substantial improvement, but, as has been noted, there results almost always a certain amount of deterioration, both physical and intellectual Sometimes it is necessary to transfer the patient to a mental hospital, where he may be obliged to remain, or after a longer or shorter time he may be able to return home again In the final stages of the disease there may be great mental deterioration and physical helplessness, so that hospital care becomes imperative.

RARE DISEASES OF THE BRAIN

Various degenerative disorders may take place in the adult brain, but fortunately they are rare There are, for example, two forms of what is sometimes known as *presenile dementia,* diseases named after famous neurologists, Alzheimer and Pick In these conditions an early dementia closely simulates that exhibited by old people It may come on as early as thirty-five or forty years of age and tends to be rather more rapid in course and to result in a complete degree of mental dilapidation, with some associated neurologic signs Unfortunately, both the cause and the treatment of these degenerative disorders are unknown.

TUMORS OF THE BRAIN

The brain is not immune to cancer and other forms of new growths, although tumors of this area are considerably rarer than in certain other tissues of the body, such as the breast, the uterus, the prostate and the intestinal tract. Some of these tumors are malignant—that is, they destroy the tissue in which they arise, and others are not destructive except by reason of the pressure that they exert. The skull being an unyielding container, a relatively small tumor may cause marked pressure symptoms The general symptoms vary greatly, depending upon the location of the tumor, its size and its type Headaches are frequent, pressure upon the optic nerve may occur, with impairment of vision, and drowsiness is a common feature. The diagnosis of these conditions is largely by the use of x-rays, by neurologic findings and by the electroencephalograph, an instrument that records the "brain waves" or electrical currents resulting from the activity of the brain cortex Brain surgery has developed tremendously in the last quarter century, and conditions formerly looked upon as hopeless and inoperable are capable of having much done for them now The important things are an early and accurate diagnosis and a competent brain surgeon.

Perhaps at this point it should be mentioned that as drugs and the toxins of disease may cause various mental symptoms, so may noninfectious conditions, such as diabetes, cancer and the like, even though these are not diseases of the brain itself An impairment of the eliminative chemistry of the body or of the ductless glands may cause various symptoms, more or less severe, and as a rule the course of these symptoms depends largely upon the course of the bodily disease in question These, however, are problems of general medicine that need not be discussed in this book

INJURIES TO THE HEAD

The subject of head injuries is one of widespread interest and receives the consideration of the psychiatrist, even though relatively few patients with head injuries find their way into mental hospitals Head injuries are very frequent in civilian life, particularly as results of automobile accidents; a great number occurred in battle. The brain is an extraordinarily well-protected organ, bathed in fluid, surrounded by dense membranes and enclosed in a bony case, the very

shape of which makes it highly resistant to blows. However, a hard blow on the skull may cause a depressed fracture in which portions of bone impinge directly on the brain tissue; even if no fracture is caused, the force of the blow may be sufficiently great to cause a hemorrhage under the tissues (meninges) surrounding the brain In such a case a blood clot may cause considerable pressure and even call for operative interference The most common symptom of brain injury immediately after the injury is loss of consciousness. This may be of varying duration and sometimes may last for several days Depending upon the area of the brain involved and the extent of the damage done, we may find localized loss of function, such as paralysis of an extremity or one side of the body Sometimes speech is affected, or there may be convulsive episodes If the patient survives, various symptoms may ensue which are directly traceable to the damage of the brain itself Some of these symptoms are headaches and dizziness, easy fatigue, convulsive seizures, irritability, some impairment of memory, difficulty in thinking and impairment of judgment Increased susceptibility to alcohol is often noted following a head injury Again, we may find silliness and childishness, petulance and impetuosity, or the patient may develop the idea that he is the victim of some sort of conspiracy and, on account of his irritability, he may make physical assaults on those about him

These symptoms are mentioned as possible after-effects of head injury. They are not always the rule by any means, and many patients make an excellent adjustment following a serious injury in which considerable amounts of the brain tissue may have been lost as a result of operation Some patients have no complaints and show no visible psychologic after-effects It may be expected that methods will be found to reduce still further the incidence of these very unfavorable results of injury to the brain

One caution may be given at this point Practically everyone has at some time or other received a blow, usually a minor one, on the head Relatives, in giving the history of a patient admitted to a mental hospital, seldom fail to mention that the patient had been struck on the head, and they often seem to attribute all of the difficulty to that blow It is worth emphasizing that brain injury as a result of a blow upon the head does not occur in the majority of cases, even when there was a fairly protracted period of unconsciousness The symptoms described above are rather limited and involve a certain amount of mental deterioration They do not simulate in any way the commoner types of mental disease; in fact, only

about one-half of one per cent of the admissions to mental hospitals are classified as belonging in the *traumatic* group. The search for a history of head injury on the part of relatives of a mental patient is usually an attempt to find a plausible explanation for a condition which is to them mysterious It should also be mentioned that a head injury, like any other injury, may be the precipitating factor in the development of a neurotic disability Many of the symptoms attributed to head injuries are often found to be fundamentally neurotic and not basically due to damage to the brain tissue itself Sometimes a mixture of the two types of symptomatology is found, and the distinction between the two is a matter for sound psychiatric judgment after careful examination

THE CONVULSIVE DISORDERS

In a chapter on organic conditions, fairly extensive mention has to be made of the group of convulsive disorders, colloquially lumped under the term *epilepsy* It has been authoritatively estimated that at least 500,000 persons in this country suffer from convulsive disorders—that is, conditions in which there are convulsions with loss of consciousness Of these only about ten per cent reach mental hospitals, but even at that 50,000 is a large number and constitutes nearly one-tenth of all of the patients in the mental hospitals of this country The epilepsies are an important question to the psychiatrist as well as to the employer and to the family Convulsive episodes may be found in such brain conditions as general paresis, tumor, arteriosclerosis, brain injury and in the presence of certain toxic conditions, such as in uremia (as in advanced kidney disease), and from the ingestion of certain drugs such as strychnine However, a large proportion of the cases of convulsions have no well-understood cause and therefore are generally referred to as "essential," which means that the cause is unknown. With the recent development of the electroencephalograph, by which the electrical activity of the nerve cells of the cortex of the brain can be recorded, there seems reason to believe that most of the so-called essential epilepsies are fundamentally hereditary in character There are persons who never have had convulsions but have typically epileptic brain waves, and it is widely assumed that they are, so to speak, carriers A known epileptic should not marry a person who has brain waves of the epileptic type, since the likelihood of epileptic offspring is considerable in such a marriage.

Epilepsy has been known since the time of Hippocrates, and the ancients called it "the sacred disease." A great aura of mystery and fear has developed about it, as a result of such widesperad folklore. Much is being done through certain lay organizations and by the publication of some excellent books directed toward the laity to dispel the fogs of misunderstanding that hover over the head of the unfortunate epileptic Furthermore, the brain wave studies being carried on and the very important work being done in the development of new drugs to relieve the patient offer great hope to the sufferers from this disorder

The onset of essential epilepsy is usually in adolescence, though many cases develop in childhood Occasionally it is delayed until maturity, and a fair number of persons have no attacks until they meet some unusually stressful situation. A good history will frequently disclose convulsions in infancy, which were thought to be due to feeding or teething difficulties or some childhood disease. Convulsions do occur in infants from these causes, but a much larger proportion of persons suffering from epilepsy give a history of infantile convulsions than would be expected otherwise

We sometimes hear described an "epileptic character," believed by some authorities to exist prior to the development of the attacks or independently of them The person is of oversensitive make-up, markedly self-centered, overreligious in a self-indulgent fashion and often appears very stubborn, perhaps because of the egocentricity that prevents him from paying much attention to anything but himself and his own desires. This type of personality undoubtedly exists in certain epileptics, showing itself in childhood and before the attacks begin, but in many others it is not especially evident.

There are three general types of seizures One, known as the *petit mal,* or the little sickness, consists essentially in momentary lapses of consciousness without convulsions The patient may be speaking and suddenly look blank, stop speaking, but not be unconscious even long enough to fall He will suddenly resume the thread of his conversation where he left off and may be wholly unaware that anything unusual has happened The *grand mal,* or the big sickness, is usually preceded by an aura; that is, a sensory disturbance in which, for example, the patient sees bright lights or has a queer feeling in the stomach, or apparently perceives a peculiar odor (this, of course, being nonexistent in reality); then comes a loss of consciousness, during which he falls, exhibits marked con-

vulsive movements, may foam at the mouth, choke or otherwise injure himself. The epileptic is often bruised from falls or suffers fractures of bones, or burns himself by falling against hot stoves or radiators. He is entirely helpless and unconscious during the seizure and needs protection and care, particularly to keep him from biting his tongue, from bumping his head on a hard surface and from swallowing any foreign bodies; but no attempt should be made to restrain the convulsive movements On account of the contraction of the muscles of the neck, it is important to loosen the collar in order to prevent suffocation Following the attack, the patient has a longer or shorter period of unconsciousness, during which he is much relaxed; sweating and exhaustion follow. As consciousness emerges, he may appear more or less confused, and sometimes this period of confusion lasts for several hours or longer Occasionally we observe marked restlessness, irritability and even a tendency to assaultiveness. This latter type of patient may be very dangerous following an attack, and for that reason he usually should be hospitalized Such a person can seldom be safely cared for at home

The third type, usually described as the "Jacksonian" seizure, is more often found in cases following head injury or brain tumor. In this condition one extremity, an arm or a leg, is affected first, often even before consciousness is affected Convulsive seizures commence in that extremity, and from that appear to spread over the rest of the body. The extremity affected depends upon the area of the motor cortex in which the excitation is greatest, the condition is often due to scar tissue following an injury to the brain or to something of the sort that acts as a local irritant.

There are various *epileptic equivalents,* particularly *fugues,* as they are known, during which the patient, instead of having a convulsion, may have an extended period of confusion and loss of identity In this state he may wander for substantial distances and do things entirely foreign to his ordinary personality In some of these periods of confusion, serious crimes are occasionally committed.

In some patients convulsions are very frequent despite medication. It seems quite likely that repeated violent convulsions, during which the pressure within the skull is substantially increased and in which head injuries may be sustained, may in themselves bring about considerable brain damage with consequent mental deterioration A small number of epileptics deteriorate almost to a vegetative level. This form of mental dilapidation results in the commitment of

a number of the patients we find in hospitals suffering from epilepsy. Others may have exhibited such irritability and assaultiveness that they cannot be cared for outside an institution, though, as noted above, nine-tenths of the sufferers from epilepsy live out their lives beyond the confines of institutions.

Treatment in Epilepsy

The treatment of the epileptic must depend largely upon the type of personality he possesses If he is the irritable, assaultive type, if he develops a psychosis or shows a progressive deterioration in intelligence and behavior, a mental hospital or institution for epileptics is the best place for him. There are some private "schools" for epileptic children, where research in treatment and in methods of training and education are carried out Other such schools are little more than custodial institutions

The principal aim in treatment is to prevent, or at least to decrease greatly, the convulsive seizures The bromides used to be the drugs par excellence, but more recently these have been almost entirely given up on account of their deleterious effect and because greatly improved drugs have been developed One of these is *luminal,* a derivative of barbituric acid, which seems to have the effect of reducing the frequency and the severity of convulsions without causing mental impairment or even much drowsiness. More recently a drug known as *dilantin* has been used with great success A diet high in fat and low in carbohydrates is often effective with children, in a fairly large number of cases the attacks cease while the diet is being given and do not return, but it is not so effective with adults. Needless to say, the treatment, whether medicines or diets, always should be administered under the supervision of a physician

There are numerous "quack cures" for epilepsy, which one sees advertised in certain newspapers and magazines: "Dr. So-and-So's medicine positively cures fits and convulsions," "A guaranteed cure for epilepsy," and so on They consist of drugs of various sorts, the best of them being those that any reputable physician will prescribe at far less cost than the quack exacts In the care and the treatment, especially of those epileptics who do not require institutional care, the co-operation of the family is essential As far as possible the patient must avoid excess and excitement Food, work and play must be in moderation, and alcohol must be strictly

avoided The physical health should be kept up to par, any foci of infection, such as teeth and tonsils, should be attended to and the bowels should be kept open Exercise should be taken in moderation Idleness must be discouraged, hobbies and interests, encouraged. Work or an occupation must be selected with care, something in which the patient can take an interest and attain proficiency, and obviously certain types of occupation such as house painting or driving trucks are out of the question The epileptic is likely to feel it a hardship to be deprived of driving a car, but in many states the danger has been recognized by law, and licenses are denied to known epileptics.

Henderson and Gillespie* emphasize that the epileptic should not have his life made miserable by unnecessary restrictions The great majority of them are capable of living normal lives if they are understood and if allowances are made for their affliction The community needs to be educated to this fact and to take its share in helping the epileptic to a suitable occupation, seeing that possibilities of danger to himself or others are minimized

With the development of the newer forms of treatment, which lower very substantially the likelihood of convulsions, and with the better medical and psychiatric management of the epileptic, a new day seems to be dawning for him Whether or not the actual causes of essential epilepsy are discovered in the near future, it seems certain that life will be made easier and more productive for its victims

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6

Alcohol and Its Role in the Psychoses

The problem of alcohol and its relation to man is as old as human history. Its use goes back into prehistory, for there seem to have been no primitive groups, no matter how low in the scale of culture, who did not know how to make intoxicating beverages and use them, even though their use was confined to ceremonial occasions or religious observances Yet about no subject is it more difficult to discover actual facts Thousands of scientific studies have been made, and other thousands not so scientific, but few of them are so coldly impartial that we can feel sure that the conclusions drawn are not colored by the observer's bias. The believer in alcohol as the gift of the gods to mankind sees one side of the picture; the total abstainer, the other. There are few subjects upon which people are more emotional and less reasonable, and yet because of its social and economic complications, none needs more careful

scrutiny and scientific research. Of this we have a beginning in the Research Council on Problems of Alcohol, organized in 1937, an independent agency which, to quote from the statement of its purposes upon its organization, "has no connection whatsoever with any prohibition or reform movement, or with any repeal agency or liquor organization. It is made up primarily of scientists whose sole purpose is to conduct an unbiased study of the relation of alcohol to the health of the individual and the welfare of society, and to disseminate the results of its study in a socially useful manner"* The first fruits of the work of the Council were published in a book entitled *Alcohol Addiction and Chronic Alcoholism,* which presents the result of a painstaking study of the present knowledge of the subjects covered In what follows we shall make considerable use of the findings of this study.

At the outset we must distinguish between what are known to the psychiatrist as "normal" and "abnormal" drinkers The normal drinker is the social or moderate drinker, who may even on occasion drink to excess but has no particular craving for alcohol and is able to control his indulgence in it. Abnormal drinking is defined by Bowman and Jellinek† as "habitual indulgence in alcoholic beverages beyond the limits of merely satisfying thirst, or of using the alcoholic beverages in the sense in which a condiment is used,‡ or in its formal social use, or as an *occasional* stimulant"

Abnormal drinking takes different forms in different people. There are steady drinkers and periodic drinkers, those who are always in a pleasant alcoholic fog, and others who are never sober, yet show few external signs of drinking Some always seek out boon companions to drink with, others are solitary drinkers, shutting themselves up alone and drinking themselves into insensibility.

In regard to the effects of abnormal drinking upon the individual, we may classify people into alcohol addicts and chronic alcoholics, although it is not always possible in practice to separate the two

Chronic alcoholism is defined by most authorities as permanent physical and mental impairment following the prolonged use of alcoholic beverages It is sometimes spoken of as "chronic poisoning," and implies actual diseases of the internal organs Not all ab-

* Bowman, K M, and E M Jellinek Alcohol Addiction and Chronic Alcoholism, New Haven, Yale, 1942, p 12

† *Ibid*, p 9

‡ That is, drinking a glass of wine or beer as an accompaniment to a meal, merely for its taste, as is the custom in many European countries

normal drinkers become chronic alcoholics, but they run the risk of doing so.

In *alcohol addiction* there is an uncontrollable craving for alcohol (or its effects), and no matter how much the person may desire to break away from the habit of drinking he is unable to do so The alcohol addict is the "problem drinker," while the chronic alcoholic furnishes most of the cases of alcoholic disease, mental and physical Bowman and Jellinek point out that all abnormal drinkers are "potential secondary addicts." In the beginning, perhaps, they are the people who can drink or let it alone, but after prolonged use of alcohol they may become habituated to it, both physiologically and psychologically, and thus find themselves in the same predicament as the "true addicts," who appear unable to do without it from the first drink.

No one can say with certainty why any person drinks unless he knows much about him—and not always then But certain types of abnormal drinkers are well known to the psychiatrist The following descriptions are limited to those upon whom authorities are in substantial agreement.

TYPES OF ABNORMAL DRINKERS

Symptomatic Drinkers

The members of this group are not primarily abnormal drinkers but abnormal personalities Alcohol is not the *cause* of their condition but a *symptom* of it These people are suffering from an actual nervous or mental illness In certain forms of psychoses people go on wild sprees or drink excessively without rhyme or reason. In the excited phase of the manic-depressive psychosis such drinking is likely to occur. In the depressive phase, people may drink themselves into a stupor In paresis, heavy drinking in a person who has always been a moderate drinker or even an abstainer is frequently the first sign of the disease. Bowman and Jellinek state that excessive drinking in an adolescent should make one suspicious of a developing schizophrenia, a disease that will be discussed in Chapter 9 Such a youth feels himself increasingly inadequate, he may begin drinking in the first place to "brace himself up" a bit, or because his crowd drinks, or because he is losing his judgment and his sense of values. He keeps on drinking as he becomes increasingly unable to adjust to reality

We have mentioned in the preceding chapter that brain injuries

and diseases like epidemic encephalitis may result in a change of personality, if not in an actual psychosis, and abnormal drinking is likely to be part of the picture. Frequently, epileptics are periodic drinkers, and the wild excesses in which they sometimes indulge have been regarded by some authorities as an "equivalent" or substitute for the epileptic attack itself.

In all these persons the alcoholism may seem to the family or the friends to be the cause of the other abnormal symptoms that they are showing, but it is not, and all attempts at reformation or treatment are doomed to failure unless the underlying personality disorder can be treated and cured.

Mental Defectives

Low-grade morons and imbeciles especially are prone to abnormal drinking, not only because of their "weak wills" or lack of inhibitions, which make them likely to follow the crowd or to yield easily to temptation, but because alcohol enables them to forget their poor status among their fellow men and feel as smart as the next one for the time being Very many habitual drinkers who spend their lives in and out of jails and reformatories are mental defectives, and instead of their stupidity's being the result of their excessive drinking, as is often believed, it is the cause of it.

Neurotic Personalities

For a vast army of sufferers from one type or another of personality disorder alcohol is a prop or a crutch or a means of escape from an intolerable situation or of disguising their own inadequacies from themselves. Among these are many who do not become abnormal drinkers, but for whom it is a temporary expedient, upon which they fall back when life becomes too much for them Others, once having discovered what it can do for them, find themselves unable to get along without it. In this latter group are many of the true addicts, those people who have an uncontrollable desire for alcohol and no matter how well they may understand what it is doing to them, cannot break themselves of the habit.

Psychopathic Personalities

Among the true addicts is another group that the psychiatrist calls *psychopathic personalities,* and toward whom he is likely to

take a rather hopeless attitude. Indeed, most psychiatrists will not undertake treatment of these people. They are frequently pleasant and likable, even charming, and able to attract and hold friends They may appear to be making a great effort to give up alcohol, they may give promises and sign pledges and enlist the sympathy and the aid of their friends. However, their resolutions are of short duration, and one who knows them well has the feeling that they are never sincere Alcohol is their other self, their closest companion, and they cannot give it up

Others of this group are unstable personalities, always in trouble and never learning anything from their experiences They have no wish to change their ways, and nothing seems to touch them emotionally or to make any lasting impression upon them They, too, are abnormal personalities; money and time spent upon their reformation is nearly always wasted.*

Other Types

Among the "secondary addicts," those persons who are not in the beginning afflicted by a craving for alcohol and drink, are many apparently normal personalities They drink in the first place because it is the custom of their group, because it helps them to overcome shyness or inferiority feelings and to have a better time at a party or other social gathering, because they feel that alcohol releases their creative powers† or affords them relaxation They are predominantly social drinkers They go on to excessive or abnormal drinking almost without knowing it. Their bodies have become habituated to alcohol, and psychologically they have come to depend upon it.

Certain occupations, too, show a high percentage of abnormal drinkers Although it is frequently said that bartenders are not drunkards, the opposite is statistically true Occupations that constantly expose people to the temptation to drink because of the accessibility of alcohol produce more than their share of abnormal drinkers.

Among "lower class laborers," the people who do the heavy and

* See Chap 12 for a further description of the psychopathic personalities.

† Bowman and Jellinek (*loc cit*, p 11) state that "alcohol as a stimulus to artistic and literary creation is frequently mentioned (in the literature) and undoubtedly in many persons this is a motive, in spite of the fact that the scientific literature does not uphold such a theory As Scharpff has put it the majority of drinking geniuses have created their masterpieces, not on account of, but in spite of alcohol."

dirty work of the world, habitual drinking is very common. The poverty and the ignorance of these people, the absence of wholesome recreation or of any prospects of a brighter future, and the usual squalidness of their surroundings, make their escape into alcoholism entirely understandable

These types of abnormal drinkers, whether they are still "potential addicts" or have reached the stage of actual addiction, are distinguished from the true addicts whose drinking is entrenched in the deeper layers of the personality, by the fact that their drinking is in response to an external situation Frequently they grow up in an environment where drinking is the accepted thing "Everybody drinks" "You need a drink." "You're not a man till you've had a good drunk" Growing up in this atmosphere, the boy begins to drink as a matter of course.

Many other types are mentioned in the literature, but perhaps this is enough to give some idea of the complexity of the problem of abnormal drinking. It is easy to see the injustice and the futility of lumping all these people together and dealing with them as "drunkards" Drunkards they may be, but back of their alcoholic habits they are personalities of many different types, and this fact determines whether they can or cannot be rehabilitated.

CAUSES OF ABNORMAL DRINKING

A description of the kinds of persons who become abnormal drinkers does not, however, tell us much about actual causes Why do people habitually drink to excess? Numerous theories have been propounded, usually based upon the observer's experience and the type of cases with which he is familiar There is no general agreement among investigators as to why one man becomes an abnormal drinker and another does not In recent years many psychiatrists and other workers with alcoholics have been inclined to see the abnormal drinker as a "psychopathic personality," not in the sense in which the term has been used above, but in the sense of a person whose physical and mental make-up is such that he cannot adjust to life in a normal fashion and finds in alcohol a solution, temporary though it be, for his personality conflicts.

Along with this often goes the theory of "hereditary predisposition," the inheritance of a constitutional make-up that results in a weak personality and perhaps an oversusceptibility to drugs. Al-

though this point of view has wide acceptance, there is, according to Bowman and Jellinek,* very little proof for it. They state:

> The untenable position that alcohol addiction is generally an expression of psychopathy has been pointed out from time to time by the greatest authorities on addiction, but in spite of this, the idea of the decisive role of hereditary liability or of psychopathic disposition has prevailed. . . All one can say is that persons with such hereditary liability or with such dispositions have a greater probability of succumbing to the risks of addiction

This means simply that the person who comes from a neurotic family or is of neurotic (or to use the layman's term, "nervous") make-up runs a greater risk of becoming an addict—once he begins to drink—than does the normal and well-balanced personality As to the direct inheritance of alcoholism—passing it on from parent to child—that is a view held by practically no authorities, and even common observation contradicts it.

Extensive investigation of the personality traits of abnormal drinkers has been made, with very inconclusive results. After observing a person who has been drinking for years, it is impossible to say whether the traits shown are the cause or the result of the drinking So far, scientists have not discovered any definite personality type that can be named "the alcoholic type." Even the "true addicts," who have in common the fact that alcohol is a necessity to them and has been from the first drink, differ in personality and appear to drink for various reasons

It is true, of course, that alcohol blunts the sensibilities and the finer perceptions and lowers inhibitions, so that in his cups a person is likely to display traits that ordinarily he can keep concealed Hence the old saying, *"In vino veritas,"* which is often translated, "What's in a man comes out when he is drunk" Many men show homosexual tendencies when drinking, thus the theory that drinking occurs on the basis of repressed homosexuality, first advanced by the psychoanalysts, is accepted by many students of the subject Another psychoanalytic theory explains alcohol addiction as a form of suicide Says Menninger,† "Alcohol addiction can be considered a form of self-destruction used to avert a greater self-destruction" There are several other psychoanalytic theories, none of which are accepted by the majority of psychiatrists. As more alcoholics are analyzed, no doubt other and more acceptable theories will be advanced

* *Op cit*, pp 20-21

† Menninger, Karl A.. Man Against Himself, New York, Harcourt, 1938, p 184

Meanwhile the search for elements in the personality that predispose to addiction goes on. Some look for it in physiology, and study the changes that take place in the body, the nutritional effects of alcoholic excess, the "tolerance," or the ability, of the body to handle alcohol, in different persons. Perhaps the majority of investigators feel that the reasons why people become abnormal drinkers lie somewhere in the personality make-up, and in the last analysis this is probably true Nevertheless, there are patent social factors that enter into the genesis of abnormal drinking, and we must look for them next.

Social Factors in the Causation of Abnormal Drinking

Human beings spend their lives in a cultural environment, "as a fish swims in water," and their behavior is largely determined by the physical facts of that environment, and by the beliefs, the customs and the attitudes of the people who share it The accessibility of alcohol is a physical fact. Obviously, when alcohol is not obtainable, people cannot drink During the years from 1918 to 1921, when Prohibition really prohibited, the number of abnormal drinkers, as judged by admissions to hospitals for mental disease and by deaths from alcoholism, was the lowest in our history. In addition, the statistics of arrests for drunkenness, of hospitalization for alcoholic poisoning and of crimes due to alcoholism all showed a sharp drop during these years. Then they began to rise, and in most areas of the United States they have been rising ever since. As everyone knows, by 1922 bootlegging had made alcohol accessible again. This is not an argument for prohibition, for it is all too obvious that man has not yet developed to the point where he is willing to forego the satisfaction of his appetites for the sake of his own welfare or that of anyone else. However, it does call attention to the fact that there are other avenues of approach to the problems of alcoholism besides the strictly individualistic one.

Again, Prohibition and the years that have followed have pointed up the fact that the attitude of society toward alcohol has much to do with its intemperate use It has become the custom in this country to drink, and all kinds of drinking habits are tolerated. Much is said about "learning to handle your liquor," with little emphasis upon the fact that for many people total abstinence is the only way to prevent liquor from handling them Some of the causes of the increase in abnormal drinking must be sought in the tendency

of human beings to follow the crowd, to do what is being done This is well illustrated by the fact that abnormal drinking is much more common everywhere among men than women. In this country there was formerly a strong social taboo against women's drinking, and until Prohibition made it fashionable, few women of the more privileged classes drank Yet for twenty years drinking among women of all social classes has been on the increase, as evidenced by the statistics from police courts, jails and mental hospitals, as well as by common observation. This increase must undoubtedly be accounted for socially. The stigma attached to women's drinking has been largely removed, and many women who would formerly have been restrained from drinking by social censure have found it easy to go to excess.

The role of poverty in alcohol addiction is stressed by many writers, and one often gets the impression that it is confined largely to the lower economic levels, since most of the statistics are based upon public institutions, where the majority of the population is drawn from the lower-income groups. That the higher income groups have their quota of addicts is evidenced by the increasing number of private institutions for alcoholics Poverty aggravates all individual ills, but there is no evidence that otherwise it plays any particular causative role in the genesis of abnormal drinking.*

However, no thoroughgoing study of the social factors in abnormal drinking has as yet been made Until it is, we lack knowledge essential to a proper understanding of the entire problem of alcohol and its place in a civilized community

THE TREATMENT OF ALCOHOL ADDICTION

The traditional treatment of the abnormal drinker has been punishment, and this still remains the method most frequently employed, in spite of the fact that fines or jail and workhouse sentences are known to have little effect in curing a man of addiction to the bottle Nor does this method, administered as it is by the police and the law, take any account of the difference between the various types of drinkers, and a great deal of public money is spent in thus punishing the feeble-minded or the sufferers from psychoses of various sorts. In the cities, the "acute intoxications" are sent to the general hospitals, where their stay

* Cf above, "Other Types"

is of little profit to anybody except the statisticians. This, however, is a long step in advance, since it recognizes that alcoholic excess is a matter for the doctor In the smaller towns, or in the country, the "drunk" is usually dumped into the jails and left there to sober up as best he may One of the first steps to be taken in a rational program for the control of drunkenness and the antisocial behavior that so often grows out of it is the education of the public to the understanding of the fact that they do not represent deliberate wrong-doing on the part of the drinker and that therefore the type of punishment usually meted out is entirely beside the mark.

Medical Treatment

When the physician first began to treat the abnormal drinker he, of course, used drugs, usually in conjunction with baths, diets, exercises and various measures designed to build up the patient's physical health and resistence, and such treatment is still very largely employed Of recent years the role of vitamin deficiencies in alcoholic conditions has been realized, and vitamin therapy is now usually employed. The "Keeley Cure" and various other widely advertised treatments apparently use the *conditioned reflex* method—that is, alcohol is given in association with other drugs that have a very unpleasant effect, so that the patient forms a distaste for it So long as he does not understand what has been done and does not take a drink, he is cured If the person so treated has stamina enough to stay away from his old companions and to attempt a real reconstruction of his life, he may be permanently cured

In addition to the bona fide medical treatment of alcoholic conditions, there are many quack treatments and self-styled "doctors" who promise unfailing cures Here, as in all other nervous and mental illnesses, it behooves the layman to be careful Most of them lighten the pocketbook, but have little effect otherwise.

Psychotherapy

The *alcoholic psychoses* have long been studied by the psychiatrist, but it is only recently that the treatment of alcohol addiction by psychotherapy has gained much headway Since most psychotherapy aims at remaking the entire personality, it is a long and

expensive process, and only certain types of persons can be expected to respond The chronic alcoholic, who has already suffered physical and mental damage, the true addict, for whom alcohol is a necessity, or the person whose real problem is a mental illness, to which the alcoholism is incidental, cannot be expected to benefit from psychotherapy directed only toward his alcoholism Neither can the "psychopathic personality," no matter how co-operative he may appear to be, ever be relied upon to contribute his share to the treatment. The psychiatrist usually insists that the person who comes for treatment shall really desire to be cured and shall be prepared to co-operate with him in every way. Treatment may be carried out in the doctor's office or in an institution, and various forms of treatment are used by various psychiatrists. Some use hypnotism and suggestion, some employ reeducation methods, some institute a period of physical treatment before psychotherapy is begun. The psychoanalyst probes deeply into mental life and seeks to uncover the very beginning of the personality Since the doctor is treating not only alcohol addiction but also *a person who has become an abnormal drinker,* it is necessary to vary the treatment to suit the individual Bowman and Jellinek estimate that, judged in terms of from two to four years of abstinence, psychotherapy as at present applied may have an average success of from 25 to 30 per cent

Other Methods

Among methods of treatment that have met with a considerable degree of success we must reckon temperance societies and religious organizations such as the Salvation Army The fundamental process here seems to be an emotional reorientation or "rebirth." The reliance upon a higher Power than oneself and the sense of security attained thereby, and especially the association with others who have trod the same path and found "salvation," may be effective substitutes for alcohol. This is the method employed by Alcoholics Anonymous, of whom we hear a good deal in the press Organized a few years ago in New York city by some ex-alcoholics who wished to remain anonymous, it has spread to many different states and now has a large membership They believe that the main cause of alcohol addiction is a wrong emotional attitude toward life, and that only a religious conversion or a spiritual experience can normalize this attitude They admit that they themselves are powerless to break away from the alcoholic habit and seek the Power that

they find in God "as we understand him." There are several steps in their program, but essentially they seek, through prayer and meditation, a religious experience. Having obtained it, they find other alcoholics and "carry the message" to them, continuing to rely upon God and seeking to carry out what they believe to be his will in their lives They form a "fellowship" that has much in common with the church, but they preach no form of theology and leave to each man his own idea of God Most of these men and women have had hospital treatment or psychotherapy, and they recommend it as a prerequisite for the steps they take for themselves.

So far we have been discussing only the abnormal drinker who is not an abnormal personality, in whom drinking is the essential difficulty and not merely a part of an underlying personality disorder. However, many people, including some psychiatrists, consider any person who habitually drinks to excess to be an abnormal personality; it is true that most abnormal drinkers suffer from personality twists and deviations, but it is difficult to say if these irregularities constitute the cause or result of the alcoholism It is probably true that abnormal drinking usually betokens emotional maladjustment in some form; and it seems clear that alcoholic addicts in general are emotionally immature No matter how intelligent they may be, they never have been able to grow up and deal with life on an adult level, their emotional attitudes are childish and adolescent They are dependent, pleasure-seeking, irresponsible, or defiant and rebellious They may be homosexual personalities, stranded in adolescence without the will or the energy to assume the responsibilities of full maturity Treatment must help them to grow up.

The Alcoholic Psychoses

The alcoholic psychoses are definitely psychotic states due primarily to the action of alcohol upon the brain and the central nervous system As medical and psychiatric knowledge advances, fewer psychoses are regarded as fundamentally alcoholic in origin, they are seen to be personality disorders quite independent of the patient's alcoholism However, some authorities believe that alcohol may be a precipitating factor in some of the nonalcoholic psychoses This view was formerly widely held by psychiatrists, and it is still the point of view of most laymen, who are inclined to attribute any mental symptoms that the abnormal drinker may show to

his alcoholic habit· "He would be all right if he would only stop drinking." But, as we have seen, this is too frequently not the case.

Most of the alcoholic psychoses are the result of *chronic* drinking; such are delirium tremens, Korsakoff's psychosis, acute alcoholic hallucinosis and chronic alcoholic deterioration Pathological intoxication and dipsomania, on the other hand, may develop as the result of a single episode of drinking or after a fairly short spree. Bowman and Jellinek, who are not stating their own opinions but giving a critical exposition of the literature, include "acute alcoholic intoxication" (plain drunkenness) among the latter group

Delirium Tremens

This condition, though by no means the most common of the alcoholic psychoses, is the best known to the layman Its striking symptoms make it unforgettable. It occurs only in persons who have been heavy drinkers over a period of years, and there is general agreement that they are the "pick of the flock", that is, they are persons who were, to begin with, psychologically nearly average and who have a high resistance to the effects of alcohol. It is *not* due to the sudden cessation of drinking, as is often believed The attack does not come out of a clear sky, but is preceded by such signs as anxiety, restlessness, fear, sleeplessness, nightmares and terrifying dreams. Then the person begins to see visions, mostly of animals, such as dogs, insects and snakes Or the room may seem to be filled with trivial objects, such as pants buttons or slippers. Everything is in movement, continually changing The patient hears noises and voices that threaten him He shows deadly fear, he does not know where he is; or he places himself somewhere in the past time He is very restless, throwing himself about, and shows tremors of different parts of the body, he may have convulsions or epileptic-like seizures. The attack itself usually lasts from three to six days or until sleep can be induced This ends the acute stages, and improvement or recovery follows. Death occasionally occurs in an attack, usually from heart failure More frequently pneumonia or some infectious disease complicates the picture, and the outlook for recovery is not good

Korsakoff's Psychosis

This condition develops in chronic alcoholics and frequently follows the second or the third attack of delirium tremens and is

accompanied by a *polyneuritis* (an inflammation of many nerves at once). In some cases there is no delirium, but the person goes into a stupor from which he can be awakened; however, if he is left alone, he lapses into heavy sleep again. Mentally, there is marked memory disturbance, disorientation in space and time (that is, the patient does not know where he is or what the date is) and "confabulations", he fills his memory gaps apparently with anything that comes into his mind There are both visual and auditory hallucinations. As the disease progresses deterioration of intelligence and emotional indifference appears as well as a tendency to harp upon the idea that some person or thing is influencing him Women are affected by Korsakoff's psychosis in about the same proportion as men, and in both the onset is later than in the other alcoholic psychoses, women, however, die more frequently.

Sufferers from this condition are better off in a mental hospital, as they need nursing care and are often difficult to manage at home. If there is money for specially trained nurses, they can be cared for at home or in a nursing home The outlook for complete recovery is not very good, although it has improved greatly since we have learned that the disorder is in large measure due to lack of vitamin-B complex, and that it is responsive to large doses of this vitamin The neuritis may disappear entirely but, some intellectual and emotional deterioration may remain

Acute Alcoholic Hallucinosis

This disease also develops in a chronic alcoholic, sometimes suddenly, more often after a period of sleeplessness, headache, feelings of anxiety and increased sensitivity to sound Then the person begins to hear voices that call him names and reproach and scold him. They carry on long conversations about him and follow him wherever he goes Frequently the patient identifies the voices as coming from certain persons. He shows marked fear and apprehension, while at the same time he knows where he is and what is going on about him Suicide is frequently attempted, the patient being driven to it by his fear of what is going to happen to him. The condition usually develops in a person from an unstable family, in which there is a more than average occurrence of psychoses, alcoholism and suicides The patient himself is frequently of a *schizophrenic* make-up· unstable, oversensitive, or shy and withdrawn. Many authorities believe that instead of being thought of

as an alcoholic psychosis, it should be considered as a "schizophrenic episode" precipitated by abnormal drinking. Be that as it may, prompt hospitalization is necessary, and when this is carried out the patient usually recovers.

Chronic Alcoholic Deterioration

Probably every chronic alcoholic arrives at this state if he lives long enough The person loses out both intellectually and morally Memory is impaired, he can no longer think clearly, waving aside questions and suggested tasks with the remark that he is not interested. He loses his ethical sense and behaves without consideration for others and even brutally, though he can still express beautiful sentiments in speech or writing He is dominated by his feelings, shows quick changes of mood and is no longer able to control his emotions, nor can he fit them to events. He is reduced beyond recognition in comparison with his former personality, and once this stage is reached, there is little to do about it except to realize that the emotional outbursts, the tendency to jealousy and the loss of intellectual grasp may make the person dangerous.

In most of these conditions we see the tendency to paranoia, which is a marked feature of so many of the alcoholic states The chronic alcoholic is suspicious, jealous and convinced that he is a victim of persecutions There are certain cases in which the usual signs of deterioration are absent, but the person (usually a man) develops ideas of his wife's infidelity. His story may be so logical and plausible that it is difficult to determine whether or not it is delusional Such persons are dangerous; they often attack their wives and certainly should be removed to an institution before such a thing occurs, yet it is sometimes very hard to prove them insane Neighbors and friends find the patient no different from his former self and in cases where the wife gives him some provocation they may be inclined to agree with him Then some day the community is startled by a murder and, frequently enough, a suicide.

When there is much deterioration the person does such peculiar things that diagnosis is not difficult, as in the case of the man who sprinkled flour over the cellar stairs in order to "count the number of men his wife had down there."

This particular set of delusions is so characteristic that some psychiatrists name the condition an "alcoholic paranoid condition." Others consider it a paranoid psychosis precipitated by alcohol.

Acute Alcoholic Intoxication

Though few people wish to admit that a state of drunkenness is in reality a mental disorder (temporary insanity), authorities readily agree that it is. "In reality," says Megendorfer, quoted by Bowman and Jellinek, "the acute alcoholic intoxication is a poisoning of the brain and can be placed side by side with the severest mental disturbance known to us"* The state of drunkenness differs in various persons, but in nearly all it involves an impairment of the mental functions that would be viewed with great alarm were its cause unknown. The sight of a drunken person for the first time almost invariably creates the impression of something terribly wrong

However, it differs from the alcoholic psychoses, which, with one or two exceptions, result from prolonged abuse of alcohol

Pathologic Intoxication

This peculiar reaction to alcohol occurs in some persons and appears to have little relation to the amount of alcohol consumed, often occurring in reaction to a very small quantity. The victim experiences blind rage and confusion, sometimes acute anxiety and delusions of persecution. Occasionally the person goes into a state of ecstasy. Afterward he remembers nothing of what occurred In this state crimes of violence are often attempted or actually committed. The duration of the attack is brief, from a few minutes to a few hours

The cause of the reaction is not certainly known, though it is said to occur in the majority of cases in persons who are of highly nervous make-up We may cite as an illustration Mrs R C, a young divorcee who was a gay and brilliant person but extremely susceptible to alcohol After one or two drinks she would become greatly confused, talk excitedly and sometimes accuse her friends of disliking her and plotting against her Once, after taking rather more alcohol than usual, she became furiously excited and attempted to assault a woman friend of whom she was usually very fond She was restrained with difficulty, but soon after fell into a deep sleep The next day she had no recollection whatever of the events of the previous evening. This woman was of a highly neurotic

*Op cit, p 88

make-up, given to deep depressions; twice she attempted suicide, and succeeded the second time.

Dipsomania

This term is applied to periodic drinking of an excessive type The person may go for considerable periods without any inclination to drink, during which time he may carry on his work or business as usual. Then one day he goes on a drinking bout, which may last for days or even weeks, or until his supply of liquor and money are exhausted. Usually he drinks alone Sometimes he has a favorite place to which he retires, where he knows he will be taken care of. So he descends "into the gutter," and comes back ragged, dirty and forlorn.

The relation between epilepsy and dipsomania has been discussed frequently, and many authorities have taken it to be a substitute for the epileptic attack Also, alcohol has been thought to be a precipitating cause of epilepsy. The question is not yet settled, although abnormal drinking is known to be greater among epileptics, and alcohol promotes attacks in epilepsy Bowman and Jellinek summarize the present view of dipsomania and alcoholic epilepsy: "neither is caused by alcoholic indulgence but they are alcoholic manifestations of underlying mental or nervous disorder."* Some psychiatrists still believe that dipsomania is a manifestation of epilepsy, but more of them consider it as related to the manic-depressive psychosis, which will be discussed in Chapter 9

Certainly, dipsomania bears small resemblances to other forms of drinking In his normal state the person has no desire for alcohol, and yet periodically acts as though under a compulsion to have it His drinking is then completely senseless, his object seemingly being to drink himself into a stupor The condition impresses most observers as a very abnormal one, and all the usual methods of handling an abnormal drinker are out of the picture The dipsomaniac is pre-eminently a case for the psychiatrist, who may not be able to cure him but certainly will know how to take care of him.

Psychoses due to alcohol formed 4 6 per cent of all first admissions to mental hospitals in 1940. If we add the 6 7 per cent who were diagnosed as alcoholics without psychoses, we have a higher admission rate than for any mental disease except those due to old age and the manic-depressive and dementia praecox groups. When

*Op cit, p 147.

we add the cases that are cared for in general hospitals, the delirium tremens and acute intoxication cases, and others that clear up more or less rapidly, we get a staggering total. It is well to bear in mind also that in this country, at least, all statistics point to the fact that alcoholism is increasing.

THE ROLE OF THE RELATIVES IN RELATION TO THE ALCOHOLIC

In no other mental aberration is the role of relatives and friends of more importance than in those conditions associated with abnormal drinking Every psychiatrist knows that the cure of the alcohol addict or the chronic alcoholic, provided he is a hopeful candidate for treatment, depends largely upon his family and the environment into which he will return. If the family is intelligent and co-operative and can learn to discard the idea of sin and its consequences, seeing in the alcoholic patient a sick personality, his chances for permanent cure are greatly enhanced. With the alcoholic as with the child, a stable and happy home is the best guarantee for future adjustment, but then people from this type of home are seldom abnormal drinkers.

If the patient must return to a home in which drinking is the accepted thing, and if he is expected to be able to "drink normally" thereafter, he is almost certain to lapse into his former habits Most alcohol addicts cannot drink normally; if they could they would not have become addicts Hard as it may seem, the only way for most of them lies in total abstinence This may mean giving up old companions, staying away from the old crowd, for few ex-addicts are Spartan enough to be able to refuse alcohol when everyone else is drinking. This entails finding substitutes, making a new set of friends, finding new interests and hobbies Our present-day social customs make it very difficult for the abnormal drinker when he tries to abstain from alcohol; it is thrust upon him from all sides, and he finds escape almost impossible. Here the temperance societies, organizations like Alcoholics Anonymous and religious organizations that stress temperance or abstinence may help the ex-addict to break away from his old associations and to form new ones in which the temptation to drink is absent.

The layman, no matter what his convictions on the subject of drinking, cannot afford to be ignorant of the role that alcohol plays in mental abnormalities. The traditional attitude of censure toward

the abnormal drinker, with punishment as the only method of dealing with him, must give way to an understanding of alcohol addiction or abnormal drinking in general as an indication of something wrong in the personality, even though it be nothing more than the adolescent attitude toward life which makes it necessary to keep up with the Joneses, regardless of the consequences To be sure, the personality cannot take all the blame, and our social customs and cultural attitudes must bear their share The more we study the subject of abnormal drinking, the more we realize how complicated a matter it is, but only by studying it from all angles and by attempting to keep an open mind have we any likelihood of being able to solve the problems, both psychologic and social, that grow out of it.

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7

Psychoses Associated with Drugs and Other Toxic Agents

Mental symptoms and in some cases psychoses of greater or lesser severity, resulting in deterioration or death, often accompany or result from the taking into the system of different substances that set upon it as poisons Examples of such substances are morphine and the drugs derived from it, carbon-monoxide gas, lead, and the toxins released into the system by certain infectious diseases.

The layman is prone to confuse the symptoms of certain psychoses, especially the schizophrenic and the manic-depressive states, with drug addiction "He acts like a drug addict," is a very common remark of relatives and friends in describing a patient who is developing one of the above psychoses "Can he be taking drugs?" is often asked in relation to a beginning paretic or any case in which a change of personality is evident Many people in this country do "take drugs" to the extent of becoming addicts to them Before the World War II, the number of drug addicts in the United States was estimated by authorities at about one per thousand The war acted as a prohibition measure, since most drugs are imported, to such an extent that the two Federal institutions (at Lexington, Ky , and at Fort Worth, Tex) for narcotic addicts had a great number of empty beds that have now been filled by the overflow of patients from the Government mental hospitals in Washington. The legal sale of drugs has been controlled in this and many other countries for a number of years, but there always has been a considerable

amount of smuggling, and doubtless will be again now that the war is over.

DRUG ADDICTION AND ITS PSYCHIATRIC IMPLICATIONS

Drug addiction is an ancient evil. People, having once found out that certain herbs or roots, chewed or smoked, gave one visions or feelings of euphoria (great well-being) or reduced one to a pleasant state of dreams and unconsciousness, used these things and could not be weaned away from them. In the Orient, opium and cannabis (hemp) were the most frequently used and still are The Chinese long ago found out that opium smoking could make a man forget his troubles and put him, temporarily at least, on an equal footing with the gods. Opium smoking never has been common in this country, probably because it involves too much paraphernalia The derivatives of opium, morphine, codeine and heroin are much easier to use and form the bulk of drugs used by addicts.

In the beginning, a comparatively small dose relieves pain and induces pleasurable feelings, but in order to obtain these effects over a period of time, the dose has to be increased constantly. The victim becomes more and more dependent upon the drug and can think of nothing except obtaining an adequate supply If deprived of it for any reason, he is miserable, restless, irritable, sleepless and in some cases suffers from delirium, hallucinations, or attacks of excitement, as well as various marked physical symptoms A change of personality almost always develops in chronic users of morphine The person becomes less efficient in his work, memory is impaired, he loses his ethical sense and ceases to have any regard for the suffering that he may be causing others He often becomes untruthful, entirely untrustworthy, suspicious and furtive, or believes that people are persecuting him Physically, he becomes feeble and emaciated, his skin is sallow and grayish, his breath foul, he loses his appetite and impresses the laymen as being a very sick man

Cocaine is not so frequently used as opium and its derivatives, often being substituted when opium cannot be obtained or to give an added "kick" to some other drug When it is used in crystalline form it is known as "snow" to the underworld, hence the term "snowbird" to indicate a cocaine addict who uses the snowlike snuff. In the beginning, following a brief period of dizziness and headache, the cocaine user feels a sense of well-being and mental alertness.

He is talkative and witty, has pleasant hallucinations and imagines all his wishes fulfilled. As the effects wear off, he feels listless and tired, becomes irritable and suspicious and must have more cocaine to pick himself up again.

Cocaine users go down hill rapidly. They lose all moral sense, desert their families and consort with the lowest characters of the underworld They are physical wrecks and succumb easily to disease or die of heart failure.

Of late years we have heard much about marihuana and the smoking of "reefers," as cigarettes made from it are called. Marihuana is obtained from the hemp plant, and its intoxicating effects have been known for at least 3,000 years Within the last twenty years its use has spread from Mexico into this country, though no one knows how many people indulge in the habit The law now regards it in much the same light as opium and cocaine, but since it is easily grown it is more difficult to control the traffic in it. Although it is not so habit-forming as opium, it is nevertheless a dangerous drug, more intoxicating than alcohol and more likely to lead to mental disease than alcohol In this country mental disease due to marihuana is not often found, probably because its use is comparatively recent, but it is stated that about one-fourth of the cases in mental hospitals in Egypt and India are caused by the drug

The following is quoted from Dr. Lawrence Kolb,* Assistant Surgeon General of the U S Public Health Service, the leading authority in this country on the subject of drug addiction:

> Marihuana produces a peculiar intoxication somewhat similar to, but more fantastic than, intoxication from alcohol The devotee takes it primarily for the intoxication, but the drug also releases inhibitions and, as with all drugs that have this effect, stupefaction is the final result When marihuana smoke is inhaled the subject becomes hyperactive and anxious, he has vague fears and may even fear death and become panicky, this is quickly followed by a feeling of calm, ease, and elation He becomes talkative and is filled with a vivid sense of happiness His limbs feel light, his legs and arms may seem to be lengthened and his head much larger than he knows it to be Sense perception is increased so that colors look brighter, sounds are clearer, sensations are more vivid, and things in general are more beautiful and more interesting than they were before, but they may seem unreal and terrifying, hallucinations of sight are common Thoughts come quicker and the subject feels that he can see to the bottom of things and solve problems much better, when as a matter of fact he is usually less efficient. . Because of the rapidity of thought it may seem to the subject that he has lived hours in the course of a few minutes.

*L. Kolb Marihuana, Federal Probation 2, July, 1938

He may become hilarious and noisy, and finally dangerous In some the sex impulse seems to be aroused, probably because the sexual object appears more attractive than before All of this ends in sleep, and the patient wakes up the next day apparently no worse off for his experience

Continued use of the drug causes insanity in many cases but very unstable persons may have a short psychotic episode from only a few doses The insanity may be of several different types, although most patients eventually recover when the use of the drug is discontinued, but there is a form of dementia caused by it from which recovery does not occur . .

The excessive use of marihuana will certainly cause some persons to commit crimes, but the prevalent opinion that anyone who smokes a marihuana cigarette and becomes intoxicated by it will have criminal impulses is an error. Marihuana is in this respect like alcohol, but probably somewhat more dangerous because of the peculiar sensations and hallucinations produced by it It releases inhibitions and distorts the judgment, and the criminally inclined person with no inhibitions and distorted judgment is likely to convert his criminal impulses into action, but the normal person who becomes intoxicated with marihuana is like the normal person who becomes intoxicated with alcohol, likely to be a nuisance to himself and to others but not dangerous.

The marihuana addict is like the opium addict and drunkard; seeking at first an escape from reality by abnormal means and unusual sensations, he sinks deeper and deeper into distress because the remedy is only transitory Through using a narcotic on numerous occasions in various situations to create pleasure or relieve pain he develops a habit whereby practically all his pleasurable and painful sensations are associated with taking the drug He becomes mentally conditioned to it so that practically everything in his environment impels him toward it, even though he may wish to quit and meet his original weakness in a normal way

There are other drugs that cause temporary mental symptoms, such as bromides, but psychoses directly traceable to their use are rare. Temporary confusional states, delirium, hallucinations and hate-reactions are common, especially when the drug is abruptly withdrawn, but when the physical effects have worn off and the addict's body is restored to its normal state, the mental symptoms usually subside However, it happens not infrequently that the drug addict is already suffering from a psychosis, and when the drug symptoms subside the psychosis is left.

CAUSES OF DRUG ADDICTION

What causes drug addiction? Why in the world does anyone wish to form a habit that can lead only to such dreadful consequences?

The answer is that no one really desires to form such a habit As in the matter of alcohol, the reasons for drug addiction are complex: partly social, depending upon the environment and the associ-

ations of the person involved; but probably much more than that, upon the type of personality. The drug addict is not merely a vicious person with naturally depraved tastes, as is so often assumed. He is an inadequate person, feeling himself doomed to failure, or one burdened with ill-health and never able to feel normal, or a sufferer from tremendous feelings of inferiority Often he is a "psychopathic personality," one of those social misfits who is a law unto himself and does not feel himself bound by the standards of fitness and decency that hold other men. Occasionally he is a normal person who, under conditions of stress and strain, finds the drug a help. Such a person may be able to control his indulgence in it, but more often he too finds himself sooner or later in the meshes of a habit that he cannot break.

As in the case of alcohol, ease of access to drugs has much to do with the formation of the habit, and we find a number of physicians and dispensing druggists who are addicts Beginning with the use of drugs for self-treatment during illness, or to relieve physical or mental pain, such persons may find themselves dependent upon them. Many people who have their first experience of drugs during an illness or operation become addicts As in the case of alcohol, the drug "does something" for such people· they find themselves more comfortable than they ever have been before and very quickly become dependent upon it.

In the two Federal narcotic hospitals the patients are mostly Federal prisoners (possession or "peddling" of drugs is a violation of a Federal law) or probationers who have been convicted in Federal courts and placed on probation for a definite period, with the stipulation that they shall be treated at the hospital Voluntary patients are also received

The Kolb classification of drug addicts, worked out after many years of psychiatric study, gives us further light upon the kind of persons who become addicts. This classification is as follows·

1. Normal individuals accidentally addicted through medication in the course of illness

2 Psychopathic diathesis.* This group comprises people who show different varieties of behavior disorders and who might be called cases of simple adult maladjustment. "Their fundamental defect is an ill-defined emotional instability which finds expression in a search for new thrills, excitement, and pleasure."†

* The term *diathesis* means a "constitutional tendency toward "

† Pescor, M J The Kolb Classification of Drug Addicts, Supplement to Public Health Reports, No 155, U S Public Health Service, 1939

3. Psychoneuroses These are the people who suffer from obsessions, phobias, anxiety, and other emotional conditions which prevent them from making a normal adjustment to life

4 Psychopathic personalities. This type is discussed in Chapter 12 They are the people who, while not psychotic, are yet gravely distorted from the normal They usually have an antisocial history not connected with drug addiction.

5. Inebriates. These are the people who have substituted drugs for alcohol, usually as a means of sobering up after alcoholic sprees.

6. Drug addiction associated with psychosis According to Pescor,* this type is very rare in the narcotic hospitals, although it is found occasionally in mental hospitals

The most common type, which might be called the average type, is the "psychopathic diathesis." This, together with the inebriate type, accounts for the great majority of cases studied in the narcotic hospitals. Such people are the "weak sisters" of the world, unable to stand its storms or face its stern realities. The frequency with which their weaknesses extend to the physical sphere also must be noted They are sufferers from chronic diseases such as heart trouble, arthritis, tuberculosis, or asthma; they have bad teeth or defective vision, in fact, they seem to have inherently weak constitutions. The causes and the reasons for such weak personalities are not yet clear, but certainly they do not come as a matter of choice.

THE TREATMENT OF DRUG ADDICTION

The usual treatment of the drug addict, until very recently at least, has been punishment Those who were apprehended as lawbreakers (and many of them are, not only for "possession and selling" but because they will steal or commit even greater crimes in order to get a supply of their drug) were given prison terms and treated as criminals Very few indeed respond to this type of treatment, and repeated arrests and prison sentences have little effect upon their subsequent behavior. The establishment of the Federal narcotic hospitals marked a long step forward in the understanding of the problem Here addicts are not treated as prisoners, even though they may be such legally, but as patients The hospitals are staffed with psychiatrists, psychologists and social workers. The addict is treated like any other psychiatric patient: he is studied from all angles and is given psychotherapy along with physical treatment and recreational and occupational therapy. This is the

* *Loc. cit.*

only way we are likely to learn much about the drug addict. Enough has been learned already to show that treatment and rehabilitation are time consuming Much of it is re-education, the patient helping of a weak, immature, even childish personality—which the majority of addicts are—to develop into emotional adulthood Most persons do not stay in the hospitals long enough for this to be accomplished, and so most of them relapse.

Undoubtedly many drug addicts never come to the attention of the law Protected by their families or friends, they manage to live out their lives or even to continue at their occupations Many persons become addicts later in life, as a result of illness or emotional strain or loss, and such people are more likely to be of the normal or the psychoneurotic types. Those who get into trouble with the law are likely to come from the lower economic strata, but drug addiction is not confined to the poorer classes, high and low, rich and poor, the brilliant and the stupid, are its victims.

What is to be done when one discovers that a friend or relative is actually taking drugs? It is easier to say what should not be done No amount of reproach, or scolding, or pleading, or angry recrimination is likely to do any good Sometimes an elderly person can be placed under the care of a physician, who will control the amount of the drug that he gets Others may be persuaded to undertake psychiatric treatment, though most psychiatrists do not like to treat a drug addict outside a hospital The opportunity to continue the use of the drug is an ever-present temptation, and the addict is an adept in the art of concealing his activities. Those who come voluntarily for treatment and are really desirous of being cured are the most hopeful of success

The type of personality that responds most readily to treatment is the psychoneurotic The psychopathic diathesis type also responds fairly readily, but he seldom of his own accord stays under treatment long enough to be really rehabilitated When he begins to feel well he thinks he is cured and becomes impatient to leave the hospital or to stop treatment and "get to living like other people again" As noted above, only long-term treatment is likely to be successful with these people. The truly psychopathic seems almost impossible to reach, as indeed he is in almost any other situation.

As an example of the psychoneurotic type we may take Mrs N. R, aged thirty-six, admitted to the hospital with a severe case of veronal poisoning She had been taking drugs of one kind or another for eleven years. Recently she had taken larger and larger

doses of veronal in the hope of getting off heroin, which she had taken for several years. When admitted, she was in a pitiable state, both mentally and physically, and required a great deal of medical and nursing care. In course of time she was able to co-operate in psychotherapy and was most willing, even anxious, to find out why she had been reduced to such a state.

Mrs. N R was one of a large and devout Catholic family, well brought up, and had been a good looking and very attractive girl. She graduated from a business high school and went to work She had numerous admirers, and everyone was surprised when she married a much older man who was not her equal, either socially or intellectually However, she went on working and held excellent positions. At twenty-five she had a major operation and was given morphine to ease her pain and restlessness It gave her, in her own words, "a heavenly feeling of peace and comfort I had never really known before what it was to be free from fear and worry"

When she recovered she continued to use the drug, making an effort from time to time to get away from it by taking something else, but never was able to break wholly away Her husband upbraided her, dragged her to confession, refused her any money She finally became unable to work, and with no money to obtain the drug, fell back upon bromides and veronal, which she took until she was very ill indeed.

Months of work with Mrs. N. R uncovered a deep-seated anxiety neurosis, tracing back, as such conditions usually do, to very early childhood. After many more months, during which she lived outside the hospital and saw the therapist regularly, she was able to go back to work and for fifteen years has maintained herself comfortably without recourse to drugs.

Miss B. L. was a very different type of personality—a small, energetic person in the early twenties, a dietitian, who came to the attention of the psychologist through routine tests, administered to all new employees Her reactions were very peculiar, and she was asked to return for further interviews This she was very willing to do, and she was followed more or less regularly for eighteen months She appeared to be a co-operative patient, producing copious dreams and childhood memories, but it soon became evident that it was impossible to distinguish between her real feelings and fabrications She soon lost her job, obtained several others but held none of them She was lazy and irresponsible; she impressed

could not say what. Convinced as we all were that she was a drug addict, it was impossible ever to "get the goods on her." She was very clever, and thought she undoubtedly had underworld connections, she succeeded in concealing her activities and continued to pose as a bewildered soul in search of help. The therapist soon became convinced that she was not a suitable case for psychotherapy, but it was hard to get rid of her When she could get attention in no other way, she attempted suicide.

Her family, who at first had written noncommittal letters saying only that she always had been "very nervous," now sent a sister to see her and to tell us the whole story. Miss B. L. had been a very difficult child, stubborn, cruel and entirely self-centered. A brilliant student, she professed to be "terribly disappointed" when her father would not send her to medical school—for the simple reason that he was a clerk on a small salary She had run away with a man whom she had met at the age of sixteen, and the family never knew whether they were married or not After her return she refused to answer questions They believed that the man had taught her to use cocaine, which she took in the form of "snow." She had been expelled from college, and her credentials were forged. She never had been able to hold a position, and there was always "much smoke about drugs," but she usually succeeded in concealing her habit Miss B. L died quite suddenly with an acute kidney condition. Her whole history indicated her classification as a psychopathic personality.

From the above discussion it is easy to see that the entire question of drugs and drug addiction is not simple. Much medical research for drugs that will relieve pain and produce comfort without being habit-forming is going on, and already some have been discovered Dispensing of drugs by physicians and druggists is well controlled, but the illegal traffic—importation and sale—is much more difficult to control As in the case of other social evils, so long as there is money to be made from it, the drug traffic will continue. So long as we shut our eyes to the mental hygiene needs of individuals and insist upon treating weaklings as though their behavior were prompted by something that we vaguely call criminal impulses, we shall have an army of drug addicts. We must not forget, too, that physiology may have something to say about drug addiction, as well as alcoholism The nutritional needs of the human body are only beginning to be known. We cannot say what chemical lacks

or imbalances may exist in a person to make him susceptible to a drug habit; undoubtedly we shall know more about it in the future.

LEAD POISONING

Since the use of lead compounds in high-test gasoline has been common in this country, psychoses resulting from inhalation of the fumes have been reported a number of times. The symptoms are sleeplessness, visual hallucinations and violent excitement Usually death follows soon Lead poisoning resulting from breathing lead dust, as happens more or less frequently in certain occupations, produces physical symptoms but not often mental ones. However, children not infrequently suffer from lead poisoning as a result of chewing painted toys or furniture, or in some other way swallowing lead, and mental retardation or other mental symptoms result. Once the damage has been done, there is little remedy for it, and it goes without saying that prevention is the only course to pursue Children should not play with painted toys (unless the paint is harmless, as is now required by law in many states) or any object likely to contain lead, and all opportunity to investigate paints and other materials containing lead should be kept away from them. Recently one of us saw a boy of fourteen, mentally retarded and physically stunted, who at the age of two got paint on his hands from handling a bucket containing white lead. He was not noticed for awhile and apparently had sucked his fingers or licked his hands He had been a bright and healthy child, but became ill with what was thought to be infantile paralysis, the symptoms of lead poisoning not being noted at first Subsequently the definite physical symptoms appeared.

As methods are developed to safeguard workers in occupations where they are likely to inhale lead dust or fumes, and laws are passed to compel the use of such methods, mental and physical damage from such causes should disappear.

CARBON-MONOXIDE POISONING

Most people nowadays know carbon monoxide as a product of the exhaust gas from automobile engines It is found also in the gas used for cooking and illuminating purposes and in coal gas Poisoning by the inhalation of its fumes is one of the domestic hazards that are said to be the most frequent source of accident and injury,

but it also occurs more or less often as the result of a suicidal attempt. Death ensues fairly quickly, but if the person is found and resuscitated, he may recover or show acute mental symptoms, depending upon the amount of gas that has been inhaled. There may be delirium or coma, nearly always followed by death, or a dreamy mental state from which the patient finally recovers, or the extent of brain damage may be so great that he never recovers

Miss A R. was a middle-aged woman who had supported herself for many years by dressmaking Following a love affair with a man who disappeared with all her savings, she turned on the gas in the kitchen stove and attempted suicide. She was found before death ensued and was rushed to a hospital, where she recovered from the acute symptoms physically but not mentally. She was admitted to a mental hospital, where she proved to be pleasant and co-operative but had no recollection of what she had done She has remained in the hospital for twenty years, a quiet pathetic little figure with some nervous mannerisms and mentally little more than a suggestion of her former self.

INFECTIVE EXHAUSTIVE PSYCHOSES

This type of mental illness is easier for the layman to understand since it accompanies or follows a severe physical strain or illness, such as childbirth, malaria, influenza, pneumonia, smallpox, acute rheumatism, scarlet or typhoid fever, or typhus. Everyone knows that during a high fever there may be delirium, convulsions and states of great confusion or perhaps stupor Such symptoms may appear before the temperature rises very high, or not until after it has returned to normal After such a severe reaction, convalescence is slow, and the patient often experiences depression and marked mental or physical fatigue after even slight exertion There may be memory defects, defects of attention, or lack of interest in one's old pursuits In children extensive brain damage may result, so that the child is mentally retarded thereafter.

There are other cases in which the illness appears to release or stir up an inherent tendency to dementia praecox or manic-depressive phychosis. One always finds in the hospitals cases of dementia praecox that have followed a severe infective illness or childbirth In such cases, the outlook for ultimate recovery is poor. Otherwise the prognosis for this class of

are often terrifying, and families expect the worst; but 70 per cent of the cases of infective exhaustion psychosis recover.

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8

Psychoses of Middle Life and Old Age

Certain periods of life seem to put more of a strain upon the organism than others do Infancy is the first of these and old age the last. Between the beginning and the end of life, the periods of puberty, when important changes are taking place in both the physical and the mental spheres, and middle life, when the reproductive function begins to decline, seem peculiarly susceptible to certain forms of mental disorder. Exactly what are the causes of this susceptibility we do not know They are probably partly physical and partly mental (emotional) and also partly constitutional. For some reason, there are people who seem constitutionally unable to withstand things that others can take in their stride However, in many cases old age does bring about definite physical changes in body and brain that seem to account for the mental defects and disorders that occur. Here again the new science of *gerontology,* the study of old age and the process of aging, is finding that old age is partly, at least, a psychologic matter. The experience of wartime confirmed this point of view, since many people who had been considered too old to take any active part in industry or professional work proved to be quite capable of a "come-back," which no one

would have expected of them a short time before Let us look first at the period of middle life

MIDDLE LIFE OR THE INVOLUTIONAL PERIOD

"Involution" is the reverse of evolution. An organ or a function evolves and develops up to a certain point, changes thereafter occur in the opposite direction. So man evolves physically until the reproductive system is fully developed, thereafter he has a number of years of reproductive life, then "involution" begins The reproductive organs lose their function and degenerative changes take place in them. In women, the uterus shrivels to half its earlier size, the ovaries cease their function of discharging an egg or eggs each month, and consequently menstruation ceases. In men, changes take place in the prostate gland, and in the testicles so that they no longer produce fertile sperms These changes in the reproductive organs are paralleled by changes in other parts of the body There are skin and hair changes, and often a disposition to put on fat, especially in women Physical strength begins to decline, and many people feel a distinct waning of energy, though this is probably partly psychologic The term *climacteric* or *climacterium* may be applied to this period in either men or women, though the more common term for it in women is *menopause,* popularly known as "the change of life"

Most women experience more or less physical discomfort during the menopause There are sensations of extreme heat (the so-called "hot flashes"), which may be accompanied by profuse perspiration, nervous feelings and palpitation of the heart, or a sensation as though the heart were "skipping beats," tingling and sometimes numbness of the arms or the legs. None of these things is serious, though it is well to consult one's physician for assurance However, in many women the menopause creates little disturbance. They pass through it with little outward evidence of nervousness or emotion. Most women, no doubt, have some "bad times" when they realize that a certain phase of life is ending for them, and they face with something of a shock the fact that they will be old before a great many years Yet in many women, comparatively speaking, there occur more or less severe, emotional upsets and some suffer nervous breakdowns from which they may or may not recover

In men, the corresponding involution takes place considerably later Though in both sexes there are wide individual variations in

the age at which involution begins, in general the man's reproductive career is about ten years longer than the woman's No matter how disturbed a man may be when he finds his sexual powers beginning to wane, men in general suffer actual nervous breakdowns at this period much less frequently than women, though when they do develop a mental disorder its symptoms differ very little from those found in women in middle life.

In women, the involutional period is roughly that of the forties, though in many cases the symptoms begin in the late thirties. Menstruation may cease normally as early as thirty-eight, or it may continue with regularity and no unusual symptoms until well into the fifties; the later in adolescence menstruation has been established, the earlier it is likely to cease. In some women, interest in sex activities begins to wane as one of the first symptoms of the menopause, in others it is ushered in with greatly heightened desire. Indeed, some women experience very little sex desire until the beginning of the menopause. These facts all play a part in the adjustment of married people during this time, and in the unmarried women may cause much emotional turmoil or abnormal behavior.

In men, the climacteric may begin at early as fifty, or be delayed until sixty-five or even considerably later. The average is around sixty Occasionally a man becomes a father when past seventy, though this is an exceptional case.

Both sexes frequently complain of a feeling that life for them is over Physically and mentally their vigor is waning; they see nothing in life ahead of them to compensate for what they are losing But many other people, especially mental workers, feel a serenity and an ability to concentrate on the task in hand that they never have known before, they may do their best work in middle life or even later. Freed from the tyranny of the emotions, the intellect has a better chance to function This fact is not sufficiently stressed in the literature It is one of the chief compensations of growing older

The unmarried woman, especially, often has periods of panic during the menopause, though she may pass through it with no unusual symptoms The number of women who at this time make unsuitable marriages or engage in clandestine affairs, who attempt to adopt a child or take on obligations that they can ill afford, who change jobs or stop work and engage in restless seeking for something better, is considerable. The advice of the psychologist or the psychiatrist is sought many times a year by women who need to be

reassured that their state is temporary and that in a longer or shorter time their emotions will be tranquilized, difficult as it may be for them to realize this truth. As one woman expressed it, after the menopause a woman is "more of a human being and not just a woman." She has a broader point of view and a broader sympathy. She can work with singleness of purpose, without being rocked by the emotional storms of her younger days

Many married women also find that the period on which they enter after the menopause holds compensations that more than repay them for what they have lost. Their lives are their own in a fuller sense. With children grown and often embarked upon their own careers, the mother can turn to work and interests that have been laid aside for years Here, again, the recent war has shown us how much the older woman has to contribute and has pointed the way to the handling of many of the problems of the older age group in the postwar world.

TYPES OF PSYCHOSES IN MIDDLE LIFE

Depression

Almost any type of psychosis may occur in middle life, a common one being *depression*. The simple depressions are exaggerated "blues" and are likely to occur in persons whose natural disposition tends toward depression.

Mrs. L. came to the hospital at the age of forty-five She was the mother of four boys, the eldest sixteen, the youngest ten Her husband had deserted a short time previously and nothing was known of his whereabouts. Mrs. L always had been a worrier. Even as a girl she was of a "melancholy disposition" and had been very unhappy in her marriage Her husband drank and only partially supported her, while much of the time she did washings to help care for the family. She never quarreled with Mr L ; she merely worried She could not manage the children, and as they grew older the situation became very difficult After her husband's desertion she ceased to try to keep things going, and exasperated neighbors reported her to the Women Police, through whom she was hospitalized

On the ward Mrs. L. sat with her hands in her lap, rubbing her fingers, and would scarcely talk. She knew where she was, remembered all that had happened, but believed that her life was utterly useless and the world would be better off without her. She would

not eat voluntarily, but when the nurse sat beside her and coaxed her she could be persuaded to eat a few mouthfuls. She took no interest in anything and asked nothing but to be allowed to sit and pick at her hands. She improved very slowly, and after many months would sew a little, finally progressing to weaving. She seldom smiled and her gloom never lifted, although she took some interest in hearing about her children who had been placed in foster homes by the Board of Children's Guardians. She became a permanent hospital resident, largely because there was no one to care for her outside As the children grew up they refused to assume responsibility for her, and she had no other relatives.

Involutional Melancholia

This is the typical psychosis of middle life. It is sometimes called "anxiety depression" or "agitated depression" because it combines depression and anxiety. Mrs. L. was both depressed and retarded, she could scarcely be persuaded to move or speak, and she did so very slowly But the depression of involutional melancholia does not show this retardation. The patient may move incessantly, walking the floor, wringing her hands, rubbing her head, or picking at her face or arms, complaining, crying, or moaning She may be apprehensive, fearful of something that is going to happen to her or to her family Frequently she is obsessed with ideas of her own sinfulness and keeps reiterating that she is not fit to live. These "sins" are nearly always sexual in nature and often refer to incidents in adolescence or even childhood, but the patient exaggerates them enormously She is going to be taken to prison or put to death, her family is to be punished because of her Other patients complain of abnormal physical sensations, there is something dreadfully wrong with their bodies and the doctors cannot discover it or no one pays any attention to their symptoms Sometimes they believe that their bodies are dead or that parts have been destroyed They are no longer real, they are not a part of the world, or the world itself is an illusion, it is not really there, it is lost. Sometimes there are hallucinations of a terrifying nature, the patient hearing the cries of her children being tortured, or voices threatening to put her or her loved ones to death by torture.

The misery of these patients is very real Their thoughts constantly center on death and destruction, and they must be watched all the time to prevent their attempting to harm themselves. They

are very difficult to care for, often refusing to eat for fear the food is poisoned or that they are taking it away from others. Henderson and Gillespie* emphasize the fact that in spite of their acute distress and the bizarre nature of their delusions, these patients seldom show intellectual impairment. The authors can corroborate this. When co-operation can be obtained—it usually can by a skillful examiner—the intellect in involutional melancholia is surprisingly clear.

In spite of the seemingly malignant nature of the symptoms the outlook for recovery is very good The disease runs its course, and the patient begins to get well The very strength of the emotional reaction is in itself a favorable symptom, as shown in most of the cases that recover. No definite period can be set for recovery—a fact difficult for relatives to understand, they often feel that the doctor should be able to say that "in six months or nine months she will be well." Some patients recover in less than a year, others not for three or four years, or even longer The following case was a long-drawn-out affair.

Mrs. G suffered a severe attack of involutional melancholia and was in the hospital for nearly eight years During a greater part of that time she was in dire distress She walked the floor and wrung her hands, she bemoaned her sinfulness and wickedness, she was in a dreadful state of anxiety and apprehension She became very thin, her face was drawn and anxious, and her eye-slits widened, giving her a staring, frightened look.

Mrs G had been a lady's maid since her girlhood, a woman of quiet habits and exemplary character She had married late and had no children. She and her husband, so far as could be discovered, were congenial and happy together. The illness had come on gradually; she complaining of being tired, of inability to work as she used to and of fear that her mistress was displeased with her She suffered from insomnia and complained of bad dreams She thought that her husband had married her out of pity, not because he really wanted her Some time passed before she became unable to work and her mental state was realized Mrs. G.'s recovery, once it had begun was rapid In a few months she had gained twenty pounds, lost her anxious look, began to smile and talk normally and expressed a wish to go home. After nearly eight years in the hospital she was discharged as having recovered.

* Henderson, D. K., and R. D. Gillespie. A Textbook of Psychiatry, ed. 6, New York, Oxford, 1944, p 269.

Anna F. exemplifies the misunderstanding of such cases that is all too frequent She was the youngest of ten children and had lived all her life in a small village, where she had taught school since her girlhood She was a quiet, intelligent person, prominent in church activities, a sort of village stand-by In the eyes of her parents she was still a young girl at thirty-eight, obedient to their wishes and effacing herself in caring for them. Then a widower of the village, whom her family considered not her social equal, began to show her attention, and in spite of family opposition she married him For a few weeks she was very happy, and the family was about to submit to the situation as gracefully as possible when she began to complain of pain in her back, thinking that she had kidney trouble. A doctor could find nothing wrong, but she persisted in her ideas, talked of how wicked she had been and became despondent The husband was much upset and took her to one doctor after another, but not until she had attempted to drown herself did anyone recognize that her trouble was mental rather than physical The family then took charge and cold-shouldered her husband out of the picture She was hospitalized, while the husband's life was made miserable by the village gossip about his part in her breakdown She was greatly depressed and gradually developed the delusion that her kidneys had been "eaten away" For months she sat on the ward, refusing to do any work or to take part in any activities, saying little to anyone, but when she was visited she talked of little except her supposed kidney condition. The family saw to it that her husband did not visit her, and as she improved she began to believe that he had deserted her He was finally persuaded to obtain a divorce on the grounds of her mental incompetence, and after three years in the hospital she was taken home by the family She was never fully rehabilitated, became seclusive, and considered herself an invalid

OTHER MENTAL ILLNESSES OF THIS PERIOD

The other mental illnesses that develop in this period have no distinctive coloring, but are probably the same disorders that we meet earlier in life Sometimes they have been precipitated by the climacterium, with no previous attacks; again, they are connected with breakdowns suffered earlier in life. People who have had depressions or manic attacks earlier may develop manic attacks or depressions in middle life, which in no way differ from the earlier ones. Occasionally, cases of dementia praecox (see Chap. 10) de-

velop in middle life, with delusions, hallucinations and the other classic symptoms. Paranoid states are not uncommon, in which the patient, instead of accusing himself of wrong doing, blames someone else. The wife accuses the husband of being interested in other women, the man believes that people are cheating him, using his name, breaking up his home Religiosity may develop, and a person who never has been unduly religious, perhaps atheistic or formal and correct in his religious life, is converted to some "new" religion, nearly always one of an occult or mystical nature.

The breakdown in middle life may be, and often is, a serious matter and should be taken seriously When, as so frequently happens, it begins as an exaggeration of the person's usual attitudes and behavior, the family is likely to be exasperated rather than disturbed by the symptoms Irritability and peevishness, preoccupation with bodily feelings, groundless fears and undue anxiety, accusations of marital infidelity, complaints of children's ingratitude and abuse, and so on, are often enough met with misunderstanding and harsh words When there is a change of personality, on the other hand, and the gay and lively person becomes quiet and depressed or weeping and complaining, when the kind parent or the indifferent one becomes harsh, suspicious and accusing, no time should be lost in consulting a psychiatrist It must never be forgotten that in the depressed states there is always danger of suicide

TREATMENT OF THE BREAKDOWNS IN MIDDLE LIFE

"Can't such cases be cared for at home?" is often asked. The answer is, it depends upon the type of psychosis, the understanding and the patience of the family, and whether or not special nurses can be provided. The simple depressions and recurrences of former similar states can be cared for at home if there is money to provide for constant attendance Involutional melancholia nearly always requires hospitalization, the paranoid states in which there are suspicion and delusions of misconduct on the part of family and friends, states that may lead to acts of violence against them, certainly call for hospitalization. In any case the advice of a competent psychiatrist should be sought without delay. Much unhappiness and many tragedies can thereby be avoided

The depressions in many cases have responded to shock therapy, especially metrazol and electroshock therapy The latter, as remarked in Chapter 3, has now largely superseded the former, being

less painful and less dangerous to the patient. Many studies indicate that it is especially effective in involutional melancholia; recoveries are sometimes spectacular, occurring almost immediately Some psychiatrists are very enthusiastic over electroshock therapy, and it is being employed in many hospitals and clinics and by psychiatrists in private practice The procedure is not entirely without risk and is certainly not a panacea However, there seems to be no doubt that it has proved itself efficacious in well-selected cases.

The depressions in general show a better response to shock therapy than the other psychotic states We must remember, however, that complications occur very frequently, and for that reason the patient should be under medical and nursing supervision during the course of the treatment It is still in the experimental stage, and what causes the remission or recovery is not yet known; but undoubtedly during the next few years, treatment by shock therapy will be developed further.

MENTAL CHANGES IN OLD AGE

Until recently, the medical profession in general has not been greatly interested in old age In 1921 G. Stanley Hall, the great psychologist, published a large volume on *Senescence,* the first serious study on the problems of aging. In it he stated that as one approaches old age, one has to become his own doctor, since no physician will take any interest in him! Happily that day is passing The increasing number of people living to old age has both forced attention upon the difficulties and diseases of the last period of life and given greater opportunity for medical and psychologic studies *Geriatrics* is the new branch of medicine that deals with the care and the treatment of the aged

Old age, or "senility," is a relative term. Some people are old, mentally and physically, much earlier than others Heredity is a factor, the best guarantee that one may have of living to old age (barring accidents, of course) is the fact that one comes from a long-lived family As remarked in the beginning of the chapter, some people are constitutionally so endowed that they are able to withstand stress, physical or mental, or both, better than others, and such people live longer and "retain their faculties" longer

Old age is a social and a psychologic matter, as well as a medical and a psychiatric one The layman's interest in it is twofold: from the standpoint of the care of aged relatives or the indigent aged in

our society and from that of his own aging. Of course, no normal young person can really anticipate his own old age, or understand it if he could It has aptly been said that we have all been children, and the least sensitive among us cannot escape some knowledge of the thoughts and the feelings of childhood, but none has been old until his time, and so none except the old can really understand old age. That fact undoubtedly makes half the tragedies of the aged Few younger people have the imagination to realize what it "feels like" to be old, and few old people have considered it worth while to tell us.

Before the World War II the tendency was to "lay people on the shelf" early The feeling of being not wanted, of having one's skills considered as of no value, of being shoved aside while younger people took one's place undoubtedly has played a large part in the disabilities of so many people in middle life and early old age Now older people's skills and knowledge are being utilized, and many of them have shown a surprising ability to take up their work again It is to be hoped that the lesson will be remembered in the postwar world.

There are some other points to remember about growing old. In general, the person with a wide range of interests, who has one or more hobbies and knows how to keep busy does not become senile as early as the idle and uninterested. Again, everyone should know that it is normal to lose the vigor and the buoyancy of youth, for memory to become less reliable, and for the ability to learn to slow down as one grows older. Very many people, when they begin to notice such changes in themselves, become panic stricken, deny these facts, or try to conceal them, or, convinced that old age is here, begin to act the part. It is much more sensible to accept them and learn to manage them, to slow down physically and work and play less strenuously, to make the notebook substitute for the excellent memory of earlier years and to take more time for learning without fretting about it.

No one can write about old age without recalling Dr Lillien J. Martin, recently dead at the age of ninety-two, who did so much to make people realize that it is, in part at least, a psychologic matter Dr Martin retired from a professorship in psychology at sixty-five. Instead of feeling that her lifework was finished, she proceeded at once to a new job She began work on the emotional problems of children, but after a few years turned her attention to the psychologic problems of the aging. She opened an Old-Age Clinic in San

Francisco, where people were encouraged to talk over their problems and were helped to handle them They learned to acquire new interests, to resume neglected skills, to take up hobbies and, as one woman expressed it, to accept the infirmities and the limitations of old age gracefully Families were helped to a better understanding of their aging members. Dr Martin herself, happily growing older and not letting age interfere with her interest in life or her adjustment to it, was an unfailing inspiration to her clients

People do not all follow the same pattern in aging Normally we may say that they become less strenuous, mellower and more tolerant, personal ambitions and strivings are not so great, and there is more time for interest in others Everyone has seen the man who, when his own children were small, apparently had little interest in or affection for them, yet he devotes himself slavishly to his grandchildren

In a great many cases, perhaps in most, the personality of the older person is what it always has been, "only more so" The mild and gentle continue to display these traits The harsh and domineering, the jealous and suspicious, the irritable and irascible, grow worse as they become older, not because of any demonstrable physical changes, but their reaction to the hardships of aging, the loss of jobs and security, the failure to find new interests and to feel themselves worth while as individuals crystalizes into bitterness They are using the same methods they always have used in dealing with their life situations The anxious and depressed and the chronic worriers also show an exaggeration of their usual tendencies as age comes on Families, accustomed to these traits in their aging relatives, may not realize when they have passed the bounds of the normal

Mrs C W, the wife of a college professor, herself an intelligent and educated woman, came to see the psychiatrist one day regarding the duty of herself and her sister toward their father, a man of seventy The old gentleman always had been of an unpleasant disposition, a harsh disciplinarian, exacting loyalty and obedience without question Now that the daughters were grown and married he continued to make demands upon them as before He could no longer work and was dependent upon his children, at first spending six months of the year with each in turn. Accustomed to his domination, the daughters continued to try to please him, but his demands grew more unreasonable until the sons-in-law finally rebelled. He was transferred to a boarding house; then he continually reproached

them for "deserting" him, though they were in fact supporting him as generously as they could well afford What should they do? He wished to move to a hotel and had a promotional scheme which he expected them to finance.

Questioning made one suspicious that the old gentleman's behavior had passed the bounds of normality, and arrangements were made to see him He was a large, good-looking man with a blustering manner, quite ready to talk about his daughters' alleged unkindness He was jealous of their husbands, abusive in talking of them, sure that they were back of his daughters' plan to "desert" him and enthusiastic about the money he could make for everybody out of promoting a summer colony on Chesapeake Bay A half hour interview was more than sufficient to prove his irresponsibility, but it was difficult to convince the daughters that he was really mentally ill.

In our experience there have been numbers of such cases Those closest to a person often fail to realize how unreasonable his conduct has become, because it is not so very different from his former normal behavior. On the other hand, as people grow older they may exhibit a change of personality and be very unlike their former selves Such changes may follow an emotional shock or a physical illness or accident In still other cases they develop more gradually, as a result of changes that are taking place in the brain.

THE SENILE PSYCHOSES

The actual psychosis of old age may take several forms There may be delirium or confusion, depression, agitation, or paranoid ideas, as well as the simple deterioration familiar to all of us as "second childhood"

As an example of the complete dementia that may follow upon a physical or emotional shock we may take Mrs. H. C, aged seventy-two, who had been a lively energetic person, a club woman, an active church worker, fond of company and conversation After the death of her only daughter in an automobile accident, she became depressed and apathetic, lost all interest in her home and friends and soon became completely demented, not recognizing her sister and not always being able to find her way about the house She continued to be active, however, and would rise very early and get breakfast for several people (there being only three in the house) and insist upon preparing dinner at any hour. Even with all

the symptoms of her mental disability, the family refused to have her hospitalized, insisting that the widowed sister should continue to take care of her Not until she had assaulted the sister and came near injuring her severely, did they realize her need for hospital care.

Psychosis with Cerebral Arteriosclerosis

This condition has already been discussed in Chapter 5. Here we need only note that it occurs in the age period under discussion Mostly, disease caused by the hardening of the arteries in the brain occurs in people past fifty, though occasionally a case develops somewhat earlier In people who have had a "stroke," however slight, one never must be surprised at the development of mental symptoms, though they do not occur in all cases.

Simple Deterioration

This is by far the most common mental disorder in the aged It varies from forgetfulness and increasing lack of adaptability up to complete loss of memory and loss of interest in everything. The old person puts things away and forgets where he places them; he tells the same story over and over, he has no interest in current happenings and desires to reminisce about his own earlier days. His forgetfulness may lead to his accusing others—often the children in the family—of stealing his belongings He stuffs his pockets full of worthless articles or wears all the clothes he can get on He "confabulates," makes up stories or tells tales, because he cannot remember He goes to sleep in the midst of the answer to a question he has asked He may lose all contact with reality, may not know where he is or recognize members of his own family, like Mrs. H C above He may become suspicious and paranoid and believe absurd things about his nearest and dearest He may be extremely irritable, to the point of assaulting those who attempt to care for him; or he may be depressed, even to the point of attempting suicide.

In short, the senile person may show any number of symptoms, more or less in keeping with his earlier personality, a caricature of it, until the brain changes have become so advanced that he is scarcely more than an infant again Many old people show a tendency to wander about, getting lost, occasionally suffering accidents

or even death, because of their inattention and disorientation or inability to recognize where they are

Not long ago a family in a suburban section of a small city was aroused at 3 A M. by a policeman, who had in tow a little old lady and her suitcase She was hunting her sister's house, she said, which was on "that hill" (she pointed in its direction). She had come in late, and "got all turned around." Her sister had promised to meet her and failed to arrive, so she started to walk She gave her sister's name and asked if she might telephone, but no one of the name was listed in that vicinity Neither the policeman nor the family he had aroused recognized the old lady's mental state; they believed her story, though it was evident that she had forgotten her sister's name Later the family learned that she had no sister, but that she herself lived alone in a house further up the hill The suitcase had been empty. She apparently had been wandering about the vicinity until the police found her.

Paranoid Reactions

Not all the sufferers from senile mental disorders lose their faculties so completely In some cases a person retains the appearance of normality but develops delusions that may be quite plausible, as in the case of an old lady, a respected member of the community, who fled from her son's home at night to the minister's house, telling a pitiful tale of abuse at the hands of her son and daughter-in-law, who had taken all her money and were now threatening to turn her out of the house She gave a detailed story of all the things that had happened to her since her son's marriage. The minister took the matter up, and a neighborhood scandal developed As a matter of fact, the old lady had been dependent upon her son for years and always had been treated with kindness and consideration in his home, but she had had delusions of mistreatment for a number of years

Paranoid states in the aged are not uncommon. Usually they are not accompanied by the intellectual deterioration we expect in most of the senile psychoses Emotion and judgment deteriorate, but the old person may retain an excellent memory and appear intellectually keen and alert When this occurs it may be very difficult to prove him incompetent The family, the nurse, or the social worker dealing with such a person may know that he is suspicious, jealous, accusing them of things that never happened, falsifying and com-

plaining; but to other people such a person is capable of rationalizing his behavior and appearing to be "a fine old man," or "a sweet old lady." As in the case of the woman described above, such people may make a great deal of trouble for their families or caretakers Occasionally they may have intervals of a somewhat better adjustment, but in general the paranoid states of old age are rather hopeless of much improvement.

TREATMENT IN THE SENILE PSYCHOSES

The majority of sufferers from simple deterioration can be cared for at home, if quarters are not too crowded and the family understands the situation and makes the necessary adjustments. Many old people become bedridden and need nursing care. Others grow very restless and must be watched constantly to keep them from wandering away Many, no doubt, would be much better cared for in institutions, but the tendency of the hospitals is to insist upon senile patients' being kept at home whenever possible In spite of this, the hospitals are full of seniles, and their number is increasing When the senile person shows paranoid reactions of any degree of severity, it is usually difficult to care for him in the home, especially when there are children It is often necessary to hospitalize these people, although almost invariably there are protests against it because of their apparently good state of personality preservation

We have to remember, too, that many old people have no families able to care for them, and in many states a good system of care for such seniles has not been worked out They crowd the County infirmaries and are often most unhappy and poorly adjusted Too many schemes for old age security have ignored the fact of the senile psychoses, but they exist in large numbers and will increase as our aged population increases The matter is one upon which every intelligent layman should keep himself informed.

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9

The Functional Psychoses: The Manic-Depressive Psychosis

By this time the reader is familiar with the functional psychoses —those mental disorders that occur without any sufficient physical reason that can be discovered and for which the actual causes remain obscure, although, as we have seen in Chapter 2, there are a number of theories regarding them and a number of lines of investigation that are being pursued

The psychoses usually classed as functional are the manic-depressive psychosis, dementia praecox and paranoia or paranoid states. In this chapter we shall discuss the manic-depressive states These lie nearest to normal experience, since all of us have periods of mild elation or excitement, and most people have "blue spells" or mild depressions upon occasion In a sense the psychosis is an exaggeration of these moods, and too frequently its seriousness is not recognized until disaster has occurred

In the true manic-depressive psychosis there are two phases: the *manic,* one of elation or excitement, and the *depressed,* though one usually appears to last longer and to be more prominent than the other Sometimes one phase seems to occur without being followed or preceded by the other, but close observation will often discover a period, however mild or brief, of the opposite phase. We have known an attack of excitement of many weeks' duration to be ushered in by a brief period, certainly no more than a half hour, in which the patient, a boy of eighteen, usually active and sociable, went to his room and lay down for a short time, remarking merely that he felt "disgusted"

THE MANIC PHASE

In the beginning, the manic attack may appear, as we have said, merely as an exaggeration of the person's usual disposition An energetic, lively, sociable person begins to work harder, to play more strenuously, to take large plans and to feel little need of rest or sleep He becomes more and more keyed up, he brushes aside all pleas to "calm down and take it easy," to "get some rest," and keeps on going harder and harder He begins to do foolish things, to spend money lavishly, to run up bills, he may go on to wild excesses and violent behavior Or he may appear to be in a playful mood, indulging in pranks and childish behavior. He is often thought to be drunk, and often enough he is, but the drinking is symptomatic and in no sense the cause of his condition

In a manic attack, both mind and body are overactive The patient may be abnormally alert and sensitive, catching sounds and movements indistinguishable to his normal companions and using his faculties more efficiently than was ever possible to him before. The boy mentioned above, who had left high school in his junior year and never had been an outstanding student, escaped from the hospital and went back to his home in a distant state, where he insisted upon returning to school Visiting a history class he astonished both class and teacher by getting up and reciting at great length on a topic that he had studied three years before Physically, a manic may perform feats of agility or strength and show a phenomenal power of endurance. He will talk and shout and sing for days on end without stopping, till he is so hoarse that he is reduced to a whisper, he will work day and night for weeks, or run about from one thing to another without stopping for food or sleep In the hospitals such excessive outlay of energy is now prevented by drug medication, though the older textbooks cite cases of manics whose extreme activity could not be controlled and who died from sheer exhaustion

It is the earlier stages of the attack, or the milder states known as *hypomanic*, that are likely to be misunderstood and consequently mishandled The following is such a case, which ended disastrously. Mr. J W., a young man of twenty-eight, came from the Middle West to take a position in a municipal university in a large Eastern city. He was a brilliant scholar, a hard worker and a good instructor, he seemed to have a fine career ahead of him However, in a short time he showed himself very gay and lively, gave some hila-

rious drinking parties and amused himself in small-boy fashion by turning somersaults on the street and by jumping in and out of cars at the imminent risk of his neck. The police arrested him, but thought him merely intoxicated and sent him home with a friend The affair got into the newspapers and he was dubbed "the playboy of X College" The college, scandalized, promptly dismissed him For the next few weeks he was good copy for the reporters who followed him about (he was the son of a very prominent family, who were unfortunately at the time out of reach in the Orient) and wrote lurid accounts of his behavior He spent money lavishly, married a young woman whom he met in a bar and went to Atlantic City for the honeymoon, where he was again in the newspapers for his extravagant behavior, which was always attributed to alcohol After several wild adventures he was finally placed in a private sanitarium, where he eluded his attendant, scaled a ten-foot wall and succeeded in escaping to his home town There he took a room in a hotel, and the next morning leaped from a sixth story window and was instantly killed

Sometimes a manic attack occurs in a person who always has been self-controlled, as in Mrs. Mary M, who was an energetic and capable person, caring for her house and family and carrying on a program of civic duties as well She was never complaining or irritable, and it came as a great surprise to her husband when she began to accuse him of imposing upon her, expecting her to entertain his relatives, not allowing her enough money, and so on She became more and more talkative and irritable, nothing suited her, she made unreasonable demands, was very impatient with the children Her speech was never bizarre or peculiar, but she jumped from one thing to another and could not finish a sentence. Thinking that she was overworked, her husband took her on a trip, but she became more and more restless and overactive, and he was obliged to return home with her Still he did not realize that she was mentally ill, but Mrs M herself knew that something was wrong and consulted a doctor, through whom she was finally admitted to the hospital

In these two cases we see the three cardinal symptoms of mania: elation or excitement, "flight of ideas," the patient's mind jumping from one thing to another, and *psychomotor activity,* overactivity of both mind and body. Many other symptoms may arise, and the mania may become acute Speech cannot keep up with the wildly racing thoughts and becomes incoherent, behavior is so irrational

that the person impresses everyone as psychotic. In this state he may be, and often is, violent and dangerous. Occasionally acute mania passes into a state in which the patient becomes delirious, is entirely out of touch with his surroundings and may have delusions and hallucinations. Upon recovery he remembers nothing of this period.

THE DEPRESSIVE PHASE

Depressions also have their well-marked symptoms: difficulty in thinking, a mood of depression and *psychomotor retardation,* a slowing down of both mental and physical reactions The depressed person feels sad and tired, "blue" In contrast with the manic, whose thoughts race until he cannot keep up with them, in depression thought moves slowly, and the person often feels that it is too much trouble to formulate his thoughts and try to express them. He talks and walks slowly, and all the bodily processes are slowed down. Pulse and respiration are slower than usual, digestive processes are retarded, and obstinate constipation is likely to occur. The person lies about on a bed or a chair and finds it very difficult to "get up and get going" in the morning Toward evening he may brighten up a bit and express himself as feeling better, but the next morning the depression and the retardation are in evidence again

There are several different types of depressions We have met some of them in the preceding chapter. In the *simple depression* there is sadness and melancholy, and the person may worry over past misdemeanors He exaggerates his faults and believes that he is a worthless person His appearance changes, he looks sad and seems to age He complains that he cannot think, that he has no interest in anything, he wishes he were dead He sits idly in one place or lies about on a couch or a bed, and when forced to move he does so very slowly He is not interested in food and complains of sleeplessness In conversation he speaks slowly, but as intelligently as usual, and he knows what is going on about him. Often enough the person realizes that something is wrong with him, while his friends adjure him to "buck up," to "snap out of it," to "go on a good drunk" Families believe that the patient is overworked, that he is worrying over an unhappy experience, that he needs to get away and have a change of scene It is difficult for the layman to realize that a depression of this type is really a mental illness The person's mind

appears to be clear, his conversation is logical, and often the difficulty in thinking is not evident, though he himself may complain that he cannot think as he used to, he cannot concentrate, that his mind is a blank.

James W, a sophomore in a large university, had been an honor student in high school, but found the going more difficult in college He finished his freshman year, worked through the summer as a carpenter's helper, though he complained of being tired most of the time and kept to himself much of the time He returned to college in the fall, but almost immediately began to say to his friends that he was wasting his time, he was not college material, he should leave and go to work He became increasingly neglectful of his studies, complained of not being able to concentrate, lost interest in his former pursuits and became careless in his dress and manners His conversation was chiefly about his having always "trifled with life," the burden he had been to his mother, who was a widow, and the utter uselessness of his life His friends plied him with drinks, which only made him gloomier, they attempted to drag him out to parties and to make dates for him, but soon gave him up as a "gloomy Gus" and left him alone Nobody realized that James was sick, until one night he locked himself in his room and shot himself, leaving a note to the effect that he saw nothing in life for him and was doing his family a favor by getting out of it.

In *acute depressions,* the person is greatly slowed down and very sad and miserable He may sit all day without moving or speaking and have to be fed, led to the toilet, and have someone attend to all his wants He believes that he has committed the unpardonable sin, he accuses himself of dreadful crimes and lives in daily expectation of being punished for them Sometimes he thinks that parts of his body are gone, that his bowels are stopped up, and he refuses food because it cannot be digested Patients sometimes complain bitterly because they are forced to eat (if necessary, they are fed through a tube*) and say that the food is ruining them, that it will decay in their bodies and bring them to a horrible death Others refuse to eat because they are unworthy, or they are taking it away from those who are starving. Such ideas may be whispered to the doctor or the nurse, or expressed in a barely audible fashion Sometimes the patient keeps them to himself and tells us about them afterward, or he may complain loudly about his sins, his worthless-

* This is not a painful process A tube is passed through the nose and on to the stomach, and through this tube the patient receives nourishment, such as eggnog

ness, or his bodily state He continues in superficial touch with his environment, though there may be hallucinations occasionally, and he frequently misinterprets events and mistakes the identity of people Thus he will assure you that his wife was here this morning, that he heard her in the hall or saw her from the window, walking up the steps, but was not allowed to see her.

In some cases the depression passes into a stupor, in which the patient is entirely passive, mute, and has to be cared for in every way like an infant He seems to know nothing and feel nothing, but on recovery he may tell us that he suffered acutely from his ideas of death and destruction.

Again there are probably many cases of "minor" depression which are never recognized as such and receive no understanding treatment. The psychiatrist in private practice sees them occasionally, though they are likely to avoid any contact with psychiatry. There are people who have "dreadful attacks of blues," who "fight through" periods of depression every so often, feeling the world "dust and ashes in their mouths" Their work suffers, they are tired all the time, especially in the mornings, but they push and pull to keep going. They develop physical symptoms and blame the depression upon them, in which case they may get to the doctor, but his treatment does them no good. They entertain thoughts of suicide and occasionally attempt it; more often they turn to alcohol and drink themselves into a stupor They seek help in religion, joining healing cults or one of the sects that claim to hold the key to the "mysteries of the soul" They strive desperately to lay hold of something that will "pull them out of the black depths" After a longer or shorter time they do come out, sometimes with a bound that carries them into an exalted or even ecstatic state, sometimes more gradually until they feel like themselves again

The depressions, from mild to severe, all have in common the threat of self-destruction Very many of the suicides of which we hear or read in the newspapers occur in an unrecognized depression, and for that reason a depression is never to be taken lightly Telling a person to "snap out of it" is nonsense; that is the very thing he would do if he could Advising him to drink is worse Alcohol is no help to the depressed patient, and it may lead to disaster A change of scene, "stirring him up," providing him with new interests, usually have no effect, and under such treatment the patient nearly always becomes worse. The essential thing for the relatives to do is

to recognize the abnormal mental state and seek the advice of a psychiatrist as soon as possible.

OTHER TYPES OF MANIC-DEPRESSIVE PSYCHOSES

There is a tendency for the two phases to exist in the same individual The depressed patient begins to get better, but does not stop at his normal state, going on into excitement or elation The manic patient, who has been shouting, singing, overtalkative and incessantly active, drops suddenly into a deep depression Or there may be a period of comparative normality, after which the patient becomes ill again Sometimes he recovers after a succession of attacks, which grow progressively shorter and milder.

For the manic-depressive patient does usually recover, and quite completely, after a longer or shorter period The attacks, however, are likely to recur The intervals between them vary We recall a woman who had had a manic attack in her twentieth year She recovered, finished school, ran a very successful business for thirty years and in the early fifties reached the hospital in a fairly deep depression Usually the intervals are much shorter than this and in certain cases there are few intervals of normality, the patient swinging back and forth between mania and depression and being unable to leave the hospital for any length of time This is known as the "circular" type of manic-depressive insanity Occasionally there are cases of *chronic mania,* in which the patient continues year after year easily excited, mischievous, irritable and quarrelsome The condition does not differ from more or less acute mania, except that the patient does not recover and usually must spend the rest of his life in a mental hospital.

There are also *mixed types* of manic-depressive psychosis, in which features of both agitation and depression occur The agitated depressions of middle life, discussed in Chapter 8, fall into this group but are usually not diagnosed as manic-depressive if there have been no previous attacks. Occasionally, an agitated depression occurs earlier, in the thirties or even the twenties.

We must note also that a single attack, either of depression or mania, usually the former, may occur and leave the person free thereafter from any breakdown severe enough to be classified as a psychosis Young people sometimes seem able to throw off the condition and live their lives normally thereafter The older the person when the first attack occurs the poorer is the outlook for recovery and freedom from ensuing attacks.

CAUSES OF MANIC-DEPRESSIVE STATES

It is clear by this time that we cannot point to definite causes in the functional psychoses Nevertheless, we cannot give up the search for causes, for only by finding them are we likely ever to discover means and methods of prevention

In the manic-depressive psychosis the layman is apt to fix his attention upon the precipitating causes, since many attacks both of excitement and depression do seem to follow specific causes, such as the loss of loved ones, disappointment of ambition, business disaster, and so on. But the history frequently shows that the person has had earlier attacks, perhaps of a milder nature, or unrecognized at the time; often enough it discloses that he is in the habit of overreacting to grief or frustration, and there is always the pertinent question as to why some people develop a psychosis in certain circumstances and others do not

There are some theories that seem to be fairly well proven, and with which most psychiatrists agree Heredity seems to play a greater part in this psychosis than in any other Kraepelin found from 60 to 80 per cent of his patients coming from families in which the psychosis occurred, and many other studies, especially of twins, have confirmed the importance of the hereditary factor The bodily make-up appears to be of importance; the psychosis frequently occurs in full-bodied, robust types who normally are well developed and healthy. The personality make-up is usually outgoing and extroverted There is unusual sensitivity to external stimuli, with swings of mood from elation to depression. In some cases the person's normal disposition is gay, jolly, sociable, and in others gloomy and foreboding. In a certain number of cases there is a considerable amount of irritability and instability: the "nervous" people who are one thing today and another tomorrow, whose life is a series of ups and downs and their behavior unpredictable.

When we study the life reactions of our manic-depressive patients and go back into their childhood histories we often find an overactive extroverted child, placed in a situation of emotional frustration. There is friction between the parents, a broken home, a dominating mother or a drunken father, a home in which the child feels no security and receives little help in handling the problems of his own personality development A child of outgoing, extroverted personality is very dependent upon his environment: he forever seeks contacts or stimulation He may exhibit much drive and en-

ergy, but it is likely to be scattered and poorly directed, or it may take him so far, and then his interest dies and his energy flags Even in childhood some people show decided mood swings, being full of mischief and activity at times and again indulging in ugly tempers and black moods. As he grows older such a child may be difficult to manage, impatient of restraint, an aggressive and disagreeable type of person. Not all children of this type develop manias or depressions, but they are the types of personality that predominate in our histories Seldom do we find a happy, secure child from a well-adjusted home developing a manic-depressive psychosis.

The psychoanalysts have been studying this psychosis for a number of years, but are not yet ready to formulate a complete theory of causes. In general they teach that in both phases of the psychosis there is a serious disturbance in the relation between the Ego and the Super-ego, and in the Ego itself, which makes its adaptation to reality impossible. In mania the Ego "throws off the yoke" of the Super-ego and gives free rein to its pleasure-seeking impulses; in melancholy the Super-ego turns the tables and punishes the Ego reality impossible. In mania the Ego "throws off the yoke" of the child's life, when he is in greatest need of normal love relationships and for some reason is unable to establish them, or if once established, he loses them This lack or loss of love becomes the pattern for later disappointments, and in maturity a depression may be precipitated by a loss of emotional security, or even the threat of it The hostility and the aggression called out in the infant by his disappointments and frustrations become repressed into the Unconscious, but in the psychosis come back in the form of fantasied aggressions against the persons of his childhood, or others who are symbolic of them These fantasies are in turn repressed, and the hostile impulses turn against himself. Hence the frequent obsession with suicide.

This is a brief and sketchy statement of the psychoanalytic explanation of the manic-depressive states As remarked above, the analysts do not feel that they are as yet able to formulate an acceptable theory of this psychosis

TREATMENT IN THE MANIC-DEPRESSIVE STATES

In discussing treatment we have to consider the severity of the attacks and the ability of the home to provide proper care Many of

the milder elations and depressions can be cared for at home, or in a nursing home, under the direction of a psychiatrist, especially if special attendants can be provided. More important is the ability of the family to understand and accept the patient, and to co-operate in every way with the psychiatrist. The depressed patient, it cannot be reiterated too often, should not be left alone, even if there has been no talk or suggestion of suicide. In some ways the depressed person is easier to handle than the elated or excited one, whose heightened drive to activity is likely to keep the household in a stir. In both phases of the illness food and sleep are problems, and the physical health in the cases of depression is poor. The person has a poor appetite, loses weight; suffers from constipation, the circulation becomes sluggish, and there is a generalized weakness.

Undoubtedly, many cases of the milder sort do weather the attacks at home, without benefit of anybody but the family doctor, and not always with him Also undoubtedly, many tragedies occur that would be averted if families and the public in general were better informed on the symptoms and the serious import of this type of mental disorder.

The duration of the attack varies greatly from one individual to another, and from time to time in the same individual. Neither the doctor nor anyone else can say how long a particular attack will last It may be very brief or of several months' duration, or even longer, and occasionally, as we have noted, the condition becomes chronic and the patient is never well for any length of time.

In the hospital the milder cases of mania are placed under hygienic regime, with plenty of rest and nourishing food hydrotherapy and occupational therapy and, where it is possible, psychotherapeutic talks with a psychiatrist or a psychoanalyst. In the more acute conditions, the patient may have to be confined to a room and be fed through a tube, since he will not take time to eat, or be given hypnotic drugs to prevent his wearing himself out. There is no routine method of treatment, but in the better hospitals, at least, each case is treated individually

The depressions also are treated according to the severity of the condition and the demands of the particular case Of late years shock therapy, by means of insulin, metrazol, or electricity, has been tried Insulin has proved to be of little value; better results were obtained with metrazol, but it has now been largly superseded by electrotherapy, with which good results have been obtained in a number of cases. The depressed cases have proved to be second

only to involutional melancholia in the number of recoveries and the length of time they have been maintained. However, the element of risk in shock therapy causes many conservative psychiatrists to hesitate in prescribing the treatment, at least until other methods have been given a reasonable trial Occupational therapy, good psychiatric nursing and, when the patient is enough improved, therapeutic talks with a psychiatrist (which help the person to understand himself and the role of environmental factors in his breakdown) are all part of the treatment in the better hospitals, which, of course, also give attention to any physical disease or ailment from which the patient may be suffering.

In a few of the stubborn and prolonged depressions of the agitated type, in which there is great tension and anxiety, an operation called *prefrontal lobotomy* (sometimes *leucotomy* or *psychosurgery*) is performed In this operation, the fibers connecting the prefrontal lobes of the brain with the large nerve center within the brain known as the *thalamus* are cut The patient loses his anxiety and his excessive emotion, but he shows a change of personality that may exist for some time Dr Walter Freeman, the leading exponent of operation in this country, warns that we must expect patients who have undergone prefrontal lobotomy to be different from their former selves, even though some of them recover to the point where they can resume their former occupations and make a fairly good social adjustment The changes in the brain brought about by the operation are permanent, and for that reason many psychiatrists feel that it should be considered only in older persons for whom all other methods have failed

The period of recovery from a manic-depressive attack is a crucial one The patient may appear to the relatives to be perfectly normal, and they cannot understand why the psychiatrist insists that he is not yet well Many a patient has been dismissed from a hospital at the insistence of relatives and against medical advice only to commit suicide or to go into a manic attack and injure himself or others, sometimes seriously

The fact that in all except the very severe cases of mania and the deep depressions the patient is in fair touch with reality and often can talk sensibly may lead relatives and friends to believe that he is not so ill as he really is "He knows everything that is going on," they say. "His mind is as keen and alert as ever " But, though he is in touch with reality, he may misinterpret it, and families are disturbed by tales about the hospital and the treatment received.

A neutral pack becomes an ice pack given to punish the patient because an attendant has a spite at him. He never sees a doctor, they pay no attention to him, he declares, the attendants are abusive, they beat him up, they kick and choke him, though as a matter of fact they have done no more than restrain him from fighting with them or with another patient. The manic patient especially is a mischief-maker, and often causes much trouble for the hospital, stirring up fights among other patients, carrying tales, writing letters to prominent people in which he gives his own version of happenings in the hosptial Families too often forget the difficulties they had with these patients at home and become disturbed at what they feel to be mistreatment in the hospital. On the other hand, they may remember only too vividly the worries and the difficulties they endured and be unwilling to give patients a trial at home when the hospital feels that they are ready for it The best advice that can be given them is to trust the judgment of the psychiatrist and the social workers who, if they have had much experience with the manic-depressive cases, will seldom err on the side of overoptimism After all, we have to remember that the great majority of these persons recover and are able to take up their usual activities again, and it is the psychiatrist's business to know when recovery has taken place, though at times it may be difficult enough for even the psychiatrist to be sure

In all the functional psychoses and neuroses, there are many cases in which the picture is not clear cut The same symptom or symptoms will occur in different mental illnesses, and the patient may pass through phases that appear now one thing and now the other Seldom does a textbook description exactly fit an individual case Each case is an individual, and his personality colors his psychosis For this reason psychiatrists wish to keep a case under observation and to study the patient from many angles before they decide upon diagnosis It is the layman's part to recognize abnormal behavior and to seek competent advice as soon as possible, remembering always that the earlier a mental illness can be recognized and given proper treatment the better are the chances for a complete recovery

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10

The Functional Psychoses: Dementia Praecox or Schizophrenia

TYPES OF DEMENTIA PRAECOX
CAUSES OF DEMENTIA PRAECOX
TREATMENT OF DEMENTIA PRAECOX

If the layman feels that he has some understanding of, and perhaps sympathy with, the manic-depressive patient, he has no such feeling in regard to the one suffering from dementia praecox. His behavior lies entirely beyond our usual experience and impresses the observer as so bizarre that it is easy to see how a more superstitious age could be convinced that here was a person possessed by devils or the victim of witchcraft

Few people who have not had experience with it, as doctors, nurses, or social workers, realize the prevalence or the seriousness of this form of mental illness Every year a great number of persons succumb to it, the majority being thereafter totally incapacitated as contributing members of society It forms the bulk of hospital cases of mental illness, from 15 to 20 per cent of new admissions being cases of dementia praecox, and fully one-half of permanent hospital residents are suffering from it. It has rightly been said that if a new physical disease appeared which attacked so many people, and especially the young, leaving them invalids for life, society would be greatly aroused and every effort made to find its cause and eradicate it Why are people not aroused over dementia praecox?

There are probably a number of reasons Its victims are withdrawn from society and remain away from it the rest of their lives, in the majority of instances, and society loses interest in them The attitude of regarding mental illness as a disgrace is still the usual one, and families are prone to hush up the fact that one of their members is afflicted by it. There is still a touch of superstition about

any kind of mental illness. It is a mysterious matter, with which most of us avoid contact. It is hard to think of it objectively as sickness.

Dementia praecox means *premature dementia* or decay of the mental powers, and was so named because the onset in the majority of cases comes in adolescence, and it was formerly believed to result in permanent mental deterioration The term *schizophrenia,* introduced by the Swiss psychiatrist Bleuler in 1911, is now very generally used by psychiatrists It denotes the main characteristic of this group of cases, a "splitting" of the personality, a loosening of the associative bonds that hold the mental functions together and enable an individual to apprehend himself as a person, with thoughts, feelings and memories reaching back into the shadowy regions of early childhood, and with the ability to imagine himself as the same person tomorrow, next year, or in the indefinite future This sense of personality the schizophrenic loses His mental life is fragmentated, "split," or divided He may even speak of himself in the third person· "He feels very well today," "He didn't like his breakfast this morning," as though he were a dual personality The splitting between thought and emotion is very prominent also, and appropriate emotions are no longer attached to ideas Amanda M, who before her illness had been devoted to her mother, receives the news of her death with a smile "So she's dead, poor lady I knew her, she was a fine woman" Then she laughs and talks to herself about irrelevant matters

Schizophrenia is a broader term than dementia praecox, admitting many cases that do not really deteriorate, even after years of hospital residence, as well as those in whom typical praecox symptoms develop long after adolescence. The tendency at present, however, is to try to sort out different types within the schizophrenic group It is obvious that not all cases so classified are classical instances of dementia praecox Some of them respond to treatment, some do not Likewise, some show much better personality preservation than others

Many psychiatrists feel that there should be a distinction made between the true schizophrenic, or dementia praecox case, and the "schizoid personality" Dementia praecox, according to this view, is constitutional Even in childhood certain traits are prominent, and the full-blown psychosis is only an exaggeration of them A child so predisposed will develop the disease even in a good environment. On the other hand, the schizoid personality is of relatively

normal constitutional make-up, but is reared in an environment full of conflict and mental stress He builds up wrong reactions, meets reality by withdrawing from it, and his behavior in many respects is identical with that of the true schizophrenic or dementia praecox It is among the schizoid personalities, say the proponents of this theory, that spontaneous recoveries take place, or that we find the favorable response to treatment.

Contrary to the onset in manic-depressive cases, in dementia praecox it is gradual and insidious. In a certain number of cases the history shows that the person always has been "different," even in childhood. In others there is a gradually developing change of personality, which the families may scarcely realize until the final break comes, which may take several forms Then, looking back, they may realize that the person has been growing different over a period of years In some cases there is no actual "mental breakdown", the person merely goes on year after year, becoming more withdrawn, more eccentric and peculiar, and increasingly unable to adjust himself to the demands of his environment

TYPES OF DEMENTIA PRAECOX

Dementia praecox may take several forms. Since Kraepelin's day it has been customary to speak of hebephrenic, catatonic, paranoid and simple dementia praecox, and we shall follow this classification in our discussion, though it must be remembered that there is no hard and fast line between the different forms, that the same symptoms may appear in all of them, and that the diseases may take one form in its earlier stages and later show the typical aspect of quite another form

Hebephrenic is the most common form of the disease The case of Leroy M is rather typical Leroy, a boy of eighteen, was sent to the hospital from the Army, where he had been but a short time. (This was in peacetime, some fifteen years ago) When admitted, he was shouting, singing, cursing, keeping up a stream of talk that consisted largely of nonsense, completely out of touch with his surroundings He believed that he was an Army officer and resented being cared for by attendants and being examined by the doctor He continued greatly disturbed for some time and then began to quiet down; still he had many absurd ideas about himself and his family· that he had "the evil eye" and had to be careful not to look at anyone he liked or admired; that he had had a "spell" put upon

him in childhood so that he never could grow to manhood—"big as I am, I'm still formed like a child"; and he had many other such fancies. Finally he appeared superficially quite well, and an attempt was made at psychotherapy However, Leroy's mental processes were so far from normal that one could get nowhere. He could not be given insight, still he believed many of his delusions and had rationalized his illness to his own satisfaction; but he continued to improve, apparently, and it was thought worth while to try him on ground parole He promptly ran away and had no trouble hitchhiking back to Colorado, where his parents lived He did not stay long and soon ran away again to wander about the country, returning home at intervals, each time more dilapidated and peculiar than ever The family finally succeeded in having him committed to a State hospital, where he has remained He does a little work on the ward, laughs and talks to himself, pays little attention to the other patients, and is described as "silly and dilapidated"

The history showed that Leroy had been a difficult child, extremely jealous of his older brother, and never getting on well with other playmates He preferred to play alone At fourteen he had what was diagnosed as a heart condition, and for several months he lay in bed, scarcely talking, and seemed to have little interest in anything His parents, of course, thought he was physically ill and catered to him in every way He gradually improved, but it was more than a year before he went back to school He did not stay long, as he was so far behind and had lost all interest in study He was then sent to a private school, but ran away in a short time He was tried in another school and at several jobs, but he could not adjust himself anywhere In despair, his father finally persuaded him to enlist in the Army, hoping that it would make a man of him. His breakdown swiftly followed

We have here the history of a "difficult" child, who had a breakdown in adolescence, somewhat earlier than usual, which was not recognized as a mental illness, but certainly must have been The normal boy of fourteen will not lie quietly in bed for months, submitting without protest to be cared for almost like an infant and showing little interest in anything His behavior after his "recovery" was thought to be willfully bad, though his intelligent parents were very patient with him The restraint and the discipline of the Army were beyond any possibility of his adaptation, and an explosive breakdown resulted By the time he got to the State hospital he showed considerable personality dilapidation.

Here we see the gradual change of personality, a lowering of energy and initiative and a loss of interest in the outside world, all characteristic of hebephrenia There may be, as in Leroy's case, a struggle for several years to make some kind of adaptation to the environment, but the hebephrenic turns his interests inward and lives his life largely in phantasy There may be periods of excitement or of very bizarre behavior, with intervals when the patient appears comparatively normal. He is likely to hear voices that call him names, give him information about his family, or tell him what to do. Sometimes he imagines that it is God's voice More rarely he has visual hallucinations, believing that he sees objects or people who are not present at all. He may entertain absurd delusions, believing himself to be some famous personage long since dead—a king, the President, or something equally absurd For years a woman in Saint Elizabeths believed herself to be King Edward VII, the difference of sex troubling her not at all Sexual delusions of all sorts are very common every year many women are admitted to hospitals believing themselves married to movie stars Both men and women believe themselves to be the victims of sexual persecution, by means of electricity, x-rays, and the like, or from people who, in spite of guards and bars, get into their rooms at night and misuse them Numerous others believe that they have ruined themselves, body and soul, by masturbation

These are some of the twisted ideas of the full-blown schizophrenic In the earlier stages of the disease they are not so much in evidence, although the person may have vague presentiments of them, be troubled with feelings of unreality, or become greatly worried over his increasing inability to meet the demands of his environment A very frequent history in hebephrenia is a series of ups and downs beginning in adolescence. There may be attacks of excitement, which are difficult to diagnose because they occur in differing mental disorders, and from which the patient apparently recovers He may finish school, attempt an occupational adjustment or even marry,* but there is a progressive let-down in mental efficiency and an increasing apathy and indifference. He becomes careless and slovenly in dress and manners, may seek low company or keep increasingly to himself Finally, he has become so peculiar that he can no longer be tolerated at home, or another attack sends him back to the hospital, and this time he does not recover.

* The male schizophrenic marries less frequently than the female, according to a study made by one of the authors at St Elizabeths a few years ago Other studies have reached the same conclusion

In the form of the disease known as *catatonia* there is a peculiar type of excitement alternating with periods of stupor. The onset is usually more sudden than in other types of dementia praecox, though a good history will usually disclose that the patient has seemed different for some time before He has lost interest in his usual activities, has appeared dreamy and indifferent, or done peculiar things Then he becomes stuporous, mute, refuses food, lies in bed with an utterly vacant look upon his face, or sits cramped in a chair or crouched in a corner, paying no attention whatever to his surroundings He may be very negativistic, so that he resists every attempt to move him He may have peculiar movements or mannerisms, or may show "waxy flexibility"—that is, his limbs may be placed in any position, even a very uncomfortable one, and they remain there as though they were not flesh and blood but molded in wax. He may either have no control over his bodily functions, or he may simply refuse to perform them Patients are frequently brought to the hospital in a shocking physical condition because relatives have not known how to care for them In this condition they can be properly cared for in no place except a mental hospital. They must be tube fed and cared for like infants This state is frequently left behind abruptly, the patient suddenly beginning to talk, or he may go into a wild excitement, in which he is extremely dangerous, assaulting attendants or fellow patients or attempting to harm himself Again, he may recover from one or two or even more attacks without the opposite symptoms occurring. He may seem entirely well, though close examination will usually show some mental scarring

Katherine R was the younger daughter of a broken home, the parents having separated when she was four Although she had few memories of her father and seldom saw him, she developed an exuberant fantasy built around him Katherine was a precocious child, doing brilliant work in school, but she was shy and "shut up in herself" in contrast with her sister, who was an active, sociable type She graduated from high school at sixteen and went on a visit to her paternal grandmother on a Virginia farm Here she became more seclusive than ever, refused to take any part in the social activities of the countryside, sat about reading or daydreaming One day she was roundly scolded by her grandmother for her laziness, but merely "looked at her in a peculiar fashion" and said nothing. The next morning she refused to get up She lay in bed, not moving or speaking, staring vacantly and giving no sign of hearing what

was said to her. When she had continued in this state all day, eating nothing, the family became frightened and sent for the doctor, who gave her a hypodermic. She paid no attention to the prick of the needle, nor did the hypodermic have any effect other than to produce a slight restlessness The physician then advised that she be sent back to her home in Washington She was so resistive that she could not be dressed, and made the trip in an ambulance The doctor whom the mother called recognized the condition and she was admitted to the hospital Here she was mute, resisting attempts to care for her, and had to be tube fed Katherine continued in this state for weeks, then began to improve, and in a few weeks more was able to go home for a day's visit. Thereafter she recovered rapidly, and for awhile she was more alert than she had been for some time

At eighteen Katherine married, and for a time seemed to get on well Then suddenly she had another attack, which lasted longer than the first This was followed by attacks of excitement, in which she believed that God was talking to her and commanding her to throw herself from the top of the Capitol For over a year she had alternating attacks of stupor and excitement. Then she recovered sufficiently to go home and stay for several years At twenty-five she was readmitted and continued to reside in the hospital until her death, several years later

Not all cases of catatonia become permanent hospital residents Some of them continue to have attacks over a period of years, but have intervals of fairly normal behavior and are able to adjust at home Others recover after an attack in early life and, though they may live their lives on a lower level than was promised in their youth, they do not have further attacks Occasionally there is a fairly complete recovery, with approximate return to a normal mental and emotional state

Another type of dementia praecox is known as *paranoia* It usually develops later in life than the other types, though occasionally it occurs in adolescence More commonly it develops after several attacks resembling one of the other forms There are delusions of various kinds, characterized by their fantastic and illogical nature and by their raggedness, or lack of any consistency and attempt at systematization In other paranoid conditions, as we shall see in the next chapter, the delusions are worked out into a consistent system The patient believes himself to be persecuted, various persons or organizations—the Catholics, the Masons, and so on—are mixed

up in plots against him, which he can only hint at darkly People make peculiar gestures at him, use words with double meanings He (or she) is used for immoral purposes in a fantastic manner. He is grandiose, being one great personage today and another tomorrow. He is responsible for deaths and disasters Says Julia K, after a destructive storm in the neighborhood, "I did that I looked out of the window and said, 'Let it snow, and that roof will fall in'" She giggles as she says it.

The course of the disease and its outcome differ little from the other types, the patient becoming more and more dilapidated and peculiar Perhaps because of its later onset, it is not likely to show the remissions or periods of comparative freedom from symptoms which many patients of other types do, especially in the earlier stages of the illness

There is still another group of cases of mental disorder, not by any means always recognized as such, which Kraepelin designated *Dementia Simplex,* "simple" dementia praecox These people are met rather infrequently in the hospitals They do not show any special delusions or hallucinations, though they may be mildly paranoid They merely lose interest in life, lack ambition, and seem to have insufficient energy to hold themselves to any special course They may have been bright, even precocious, children, or they may always have been dull and colorless.

Gloria Z has been a resident in the hospital for many years, though if she had had a different type of home she probably would have remained in it Gloria, the only child of her parents, was born to them late The father was a famous mathematician, and the mother had also been a college teacher before her marriage The child, brought up in Europe, was very precocious Her father tutored her in mathematics, her mother saw to it that she learned languages. She early showed musical talent and began studying the violin at three She was a good child, but cared nothing for other children and was always in the company of older people Things went smoothly enough until adolescence, and then Gloria began to slump She lost interest in her lessons, so her father, thinking she needed a change of scene, took her to the Orient for a year's travel. She became more and more disinterested, finally demanded that she be taken home as she was tired of travel. At home she spent hours dreamily playing the violin but refusing to take any more lessons· she could play well enough, she said Baffled, her parents took her to famous physicians, who could find nothing wrong phys-

ically. When Gloria was sixteen her father died. Though they had been very close companions, she did not seem to grieve for him, and when her mother, exasperated at her behavior, upbraided her for her heartlessness, she became very angry and upset. After that she acted irritable and ugly toward her mother, who was approaching old age and felt unable to cope with her

They returned to the States, and Gloria was placed in public school, as very little money had been left for them. Here she did absolutely nothing, though on one occasion she astonished the principal by working a very difficult problem in calculus and taking it to him with the remark, "Here's what I want to do I can't stand those little kids in math." She soon refused to attend school and sat about at home or wandered aimlessly about town At the age of eighteen she was admitted to the hospital, where she has remained contentedly ever since. She is now nearing forty From being a precocious child, she had developed into a very ordinary woman, her excellent memory remains unchanged but she has few interests and no ambitions She is a good worker in a routine fashion, but has been quite content for years to do menial tasks such as ironing in the laundry She never touches her violin, and her conversation is about trivial happenings of the hospital day.

Hospital cases of simple dementia praecox are few in comparison with the number who live their lives outside or are denizens of jails and almshouses rather than hospitals Many who have homes able to care for them continue in the community, known to others as queer, or lazy, or spoiled good-for-nothings, or whatever epithets their acquaintances see fit to tag them with. They are "village characters," "sages of the countryside," mild trouble-makers, perhaps, or thorns in the flesh to their relatives Or they are mild tempered, overreligious, believing themselves set apart from other men —as indeed they are One gentle soul of this sort was a well-known figure for years in a large Eastern city, wandering about the downtown streets or taking his station near the door in one of the big department stores, where he stood patiently, a striking figure with his long curly beard and hair falling to his shoulders. He contemplated the crowd in a dreamy fashion, but always answered courteously when addressed.

Others are tramps, hoboes, vagrants, irresponsible and shiftless. They fill the ranks of the unemployed, living from hand to mouth; and their homes are the "flop-houses" or the railroad "jungles." They do not have enough energy and initiative to commit major

crimes, but are petty thieves or stool pigeons for more normal criminals They are often confused with the feeble-minded, but they are not mental defectives Their general level of intelligence may be low, but there are always remnants of old knowledge and evidence of capacities that the feeble-minded do not possess. As children, they may be dull and slow in school, although capable of much better work when their interest can be aroused, and intelligence tests will show them not greatly retarded. Often, however, they are bright or even precocious children, though their interests are one-sided; they seldom make good social contacts Adolescence nearly always brings out their fundamental energy lack, and they seem to be unable to cope with the psychologic and social adjustments that the adolescent in our culture has to make

How many such persons there may be found in our culture we do not know, but probably they are numerous As a rule they are harmless, though they may be irritable and ugly tempered if pushed too far If there is money to care for them they may spend their lives quite happily, delving into philosophy or politics, or religion, or puttering at one minor hobby after another They are full of grandiose schemes that never mature, living in a world of their own, often as solitaries and hermits They are recognized as queer or eccentric, but few people realize that their lack of energy, the apathy of the emotional life and the unused intelligence are marks of actual mental illness The condition is irreversible, no one ever has been known to recover from it.

CAUSES OF DEMENTIA PRAECOX

We have seen that no theory of the causation of dementia praecox broad enough to satisfy all psychiatrists has as yet been developed A few years ago the Scottish Rite Masons of the Northern Jurisdiction appropriated money for a comprehensive research program, and a concerted attack is being made upon the problem from many different angles Perhaps in a few years more we may know fairly definitely why certain people develop this form of mental illness The situation is much like that in regard to cancer, a great deal has been learned, but no definite cause or causes have as yet been demonstrated

Here are some of the things that we do know about dementia praecox Heredity plays a part, from 50 to 60 per cent of the patients having records of abnormalities (not necessarily dementia

praecox) in other members of their families It is not the main factor, however, and even when heredity is heavily loaded, environmental factors often seem necessary to precipitate the psychosis It occurs often in people of *asthenic* body build, that is, the constitutionally weak and poorly developed, whose energy seems to be insufficient to carry them through to a normally rounded-out maturity. These are the "constitutional types," the true schizophrenics mentioned on page 137. The childhood history of these people usually shows a withdrawn, seclusive individual, unable to make satisfactory social contacts, often described as sensitive, overimaginative or dreamy, serious minded, or "nervous" As such a child develops he finds it harder and harder to adjust to the demands of life, and his interest and energy turn increasingly inward He builds his own reality out of fantasies and wishes, rejects the external world, and finally comes to live in a world of his own August Hoch designated such personalities the "shut-in type," following Meyer's description of them as "withdrawn, seclusive, apathetic and asocial," and anyone who works with dementia praecox patients is definitely aware of the wall that shuts these people off from the warm human contacts that we expect from our fellows There is always a point beyond which one cannot go, no matter how good the rapport between the praecox and another person may seem to be

There are other people who apparently have good bodies and in whom the shut-in tendencies are not so evident in early life, yet a schizophrenic psychosis develops in them They are unable to meet and handle reality in a normal fashion and they make their adjustments by withdrawing into a reality more to their liking in their own minds It may be that if we knew these people better we would discover in them the early traits that are in evidence in the other group Some of the psychoanalysts* insist that the schizophrenic is a hypersensitive personality who has been driven into his shell by repeated hurts and has become afraid to risk being hurt again

It must be noted, too, that dementia praecox is a regressive psychosis. The patient slips back to a childish level of thought and feeling, or even farther than that, to the childhood of the race. Some of the fantastic rituals and very peculiar ideas of these patients are reminiscent of the beliefs and the practices of primitive savages.

* Notably Frieda Fromm-Reichmann, who has spent many years in the study of dementia praecox patients.

But why this is so, or what can happen to the mind of present day man to make such a type of thinking possible, is unknown.

A question frequently asked the psychiatrist is, "Should people who have dementia praecox relatives marry?" It cannot be answered by yes or no, but only by a knowledge of the circumstances If both parties are themselves healthy and normal personalities, the chances of healthy offspring are perhaps as good as the average If both belong to families in which there are a number of mental abnormalities as well as praecox, the risk is greater than if one of them belongs to a fairly healthy family. Perhaps in the former case the risk is almost too great to take, and yet no one can predict with certainty that they will have defective offspring In any case, since dementia praecox does not follow the Mendelian law, all the offspring will not be defective.

As to marriage with a person who has once had a breakdown or who appears to have a "schizophrenic personality," that is another matter, not so much from the standpoint of heredity, as from that of the kind of spouse or parent such a person may make. It is hard to realize, when a person appears to be normal, that he may again have a breakdown, or indeed that he may not be as well as he appears. In the course of many years in hospital work, one knows a number of marriages between patients (not always recovered) and nurses or others T' - ' ' ' ' ' and even in these days of easy divor _ ,ually ensues Anyone who marries a person who has once had a schizophrenic psychosis should do so with his or her eyes open and be prepared to accept and deal with whatever difficulties may follow

TREATMENT OF DEMENTIA PRAECOX

In the hospitals the treatment of dementia praecox or schizophrenic conditions has been largely "symptomatic"—that is, the patient is treated according to the symptoms that he presents It is obvious that a wildly excited catatonic must be treated differently from the silly hebephrenic, who is content to sit all day and listen to his voices. Some must be stimulated, some quieted. Hydrotherapy, occupational therapy, recreation, a good physical regime, all play their part in helping the patient to adjust to hospital life Psychotherapy is employed with cases that are able to co-operate, and in a few hospitals psychoanalysis is carried on with selected cases Although most psychiatrists do not believe that psychonalysis is very

successful in schizophrenic cases, especially in the true dementia praecoxes, its use as a research tool would seem to be justified.

A number of years ago we began to hear about insulin shock as a treatment tool in dementia praecox. In a short time patients all over the country were being given insulin, and many psychiatrists were very enthusiastic about it Further experience and follow-up studies have changed the picture somewhat. Certain patients do respond well to insulin shock, apparently recover, or are much improved, and maintain their recovery or improvement after the treatment is concluded Others improve and then relapse, or show ups and downs of progress Others do not respond to the treatment and continue in the same state as before The longer the disease has existed before treatment the less likelihood is there of a good response Nevertheless, the percentage of recoveries under insulin treatment is higher than in hospital cases without it, and as the selection of cases and the technic of treatment are refined many psychiatrists are hopeful of still better results

Metrazol and electro-shock therapy have also been employed in dementia praecox, with conflicting results. Some psychiatrists claim success, and others consider them of little value Much research is under way in search of new methods of treatment, both of a physiologic and a psychologic nature

The greatest obstacle in the way of the successful treatment of dementia praecox, whether by shock therapy or any other method, is the comparatively late stage at which it gets into the hands of competent physicians In most cases, the disease is well established by the time the patient reaches the hospital, many times it has undoubtedly been going on for years

When an adolescent begins to show unusual behavior, losing interest in his work, becoming dreamy and preoccupied, developing peculiar habits or indulging in unprovoked rages and temper tantrums, the psychiatrist is apt to be the last person consulted The usual course is a change of schools, tutoring, scoldings and punishment All kinds of "doctors" may be tried out and, since the tendency is for the sufferer to appear better at intervals for the first few years, the seriousness of the condition is all too frequently unrecognized

To be sure, all cases of adolescent difficulty are not dementia praecox Parents and teachers should know much more than many of them do about the usual ups and downs of adolescence, the majority of them are perfectly normal and only need patience and

some understanding of adolescent psychology on the part of the elders to enable the youngster to weather these ups and downs They are distinctly different from the difficulties that beset the young schizophrenic. The normal adolescent daydreams, but not to the exclusion of his interest in reality. He may be painfully shy and bashful for a period, but he does not withdraw into himself and shun contacts with his fellows One of the main characteristics of normal adolescence is the desire to be like the group, to do what the others are doing. An inability to sense the difference in himself, or an indifference to it, is a danger signal

The real beginnings, however, undoubtedly lie farther back than adolescence If dementia praecox is a "life-reactive disorder," we must look for its beginnings in childhood and even back of that, in the kind of parents from which a child comes—not so much perhaps in the way of the heredity they give him as in their ability to provide an environment in which he can build his interpersonal relationships upon a stable and normal basis So far as we know now, the best guarantee against any kind of adult maladjustment, barring accident or organic disease, is a childhood spent with normal and well-adjusted people, preferably one's own parents.

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11

The Paranoias

CAUSES OF PARANOID REACTIONS
TYPES OF PARANOID REACTIONS
TRUE PARANOIA
PARANOID STATES OR CONDITIONS
OTHER PARANOID CONDITIONS
TREATMENT

In this chapter we shall examine the mental states that may be grouped together under the term *paranoia*. They differ from the other mental diseases in that the personality does not appear to undergo the distortion that it does in the conditions we have been discussing No matter how absurd or unfounded the delusions, the person entertaining them is still able to appear normal and to react in normal fashion to matters outside his delusional system To the layman the difficulty appears to be more of a character defect than a mental disorder

Examining the term more closely, we see that it means literally *beside the mind* (it might be translated *thinking awry*), a deviation from the commonly accepted ways of thinking, so that the paranoid person may believe in all sincerity things that look entirely illogical or unreasonable to the rest of us. These are the "paranoid delusions," which in some cases may seem reasonable enough if we can understand the point of view from which the paranoid person started On the other hand, they may be so fantastic and illogical that it is impossible to see how anyone can keep on believing them, but the paranoid is absolutely convinced of the rightness of his position No amount of argument, of showing him where and how his conclusions do not square with reality can shake his belief in his own impregnable logic, and frequently enough because of his strong conviction, he convinces other people of his rightness or his divine mission. Hitler and Mussolini are not the only paranoiacs in history, there have been many of them in high places all the way along, and unless the layman learns to recognize them as abnormal personalities and not to be influenced by them, the world will con-

tinue to have paranoid rulers and leaders, and social catastrophes equal to or greater than World War II may be expected to follow.

CAUSES OF PARANOID REACTIONS

Psychiatrists, while not agreeing on the specific causes of paranoid reactions, are fairly well agreed upon the kind of personality in which they are most apt to develop The sensitive, suspicious, jealous, ambitious type of person, governed by his prejudices, and so rigid that he seems unable to change his attitudes once they are formed is fertile soil for a paranoid psychosis, even if he never goes beyond paranoid reactions, which we all may have upon occasion By "paranoid reactions" we mean suspiciousness, jealousy, a tendency to blame others for our own shortcomings, to see biased meanings in things. The normal person, however, is quite willing to drop these ideas when he is shown differently or when he gets over a temporary grouch Not so the paranoid person, he keeps on believing them in spite of all proof to the contrary

The paranoid is frequently enough a sufferer from feelings of inferiority They may be based upon his failure to attain his ambitions, or upon negative feelings associated with sexual misdemeanors or sexual incompetency He cannot bear his inferiority feelings and converts them into their opposite—that is, the others dislike and persecute him, so he thinks, because they realize his real superiority to them The psychiatrist who probes very deeply into a paranoid personality (a difficult thing to do except in the early stages) quite frequently uncovers a timid, sensitive child, cowering in real or fancied inferiority before a reality too harsh for him Apparently, once he has build up the system of false ideas or delusions that enable him to endure this harsh reality, he dares not let go of them. He projects his own hatred and aggression and feels them as coming from others Thus he can remain convinced that he is right and "the others" are wrong, and so can maintain his self-respect

Paranoia does not come to full development in childhood However, it can be traced back to adolescence in many cases, and it is here, where so many new adjustments have to be made, that the failure in adaptation seems to begin It seldom becomes so great as to stamp the person as abnormal until full maturity is reached Paranoids as a group are the oldest of our mental patients, the age of admission to the hospitals usually being past thirty years Since

they are mostly unsocial persons, keeping more or less to themselves and not really confiding in others, they may hold their own for many years, known perhaps as difficult, surly, or peculiar people, they do not suffer a real breakdown until some unusual strain, mental or physical, proves too much for them. Many persons whom the psychiatrist would recognize as paranoid never get to the hospital at all They manage to sustain themselves in the community by "taking it out" upon their families or their subordinates A wife may endure years of her husband's jealousy and accusations of infidelity, a child may be unjustly blamed and punished all through his childhood by a paranoid father, or nagged at and made miserable in a thousand ways by a paranoid mother. The paranoid may center his delusions within the family to such an extent that business and professional associates are unaware that he harbors them, as in the case of Mr J B , who was the principal of a well-known boys' school. J B was a very intelligent man and a hard worker, though his teachers never knew him very well, they respected him He was prominent in the educational work of the State, he wrote and lectured and was regarded as a leader in his field. When his wife left him the whole community was shocked and felt inclined to blame her altogether It gradually became known that he was extremely jealous of her; for years he had accused her of infidelity, had refused to let her leave the house without him; finally convinced that she was harboring men in the house, he insisted on locking her in her room each night while he searched the house from garret to cellar.

As a group, the paranoids are the most intelligent of all our abnormal personalities Often they are educated and talented persons, although more often they are intelligent and talented but never have had the opportunity to develop their talents or to acquire an education Many times, too, the delusions are quite plainly fancied wish-fulfilments, as in the case of the old gentleman who tells us fantastic tales about his degrees and honors, though his school record actually stopped at the seventh grade.

The psychoanalysts interpret paranoia as due to some defect or deficiency in the sexual sphere, and it is true, as all observers agree, that sexual delusions are to be found in many, perhaps a majority, of the cases of paranoia; where they are not frankly sexual they can usually be found to be symbolic of sex. Thus men fear homosexual assaults, or believe that other men accuse them of being "fairies" or perverts. Women believe themselves married to famous

persons or to have numerous lovers or to be the victims of sexual persecution. It remains to be explained why some persons suffering certain frustrations should develop these delusions and others do not Some psychiatrists believe there has to be a constitutional factor at the bottom of the paranoid personality, though we do not yet know what it is.

The delusions themselves may be "ideas of reference," a belief that events and occurrences in the environment have a special meaning for a person, people glance at him in a meaningful way, they are always talking about him, newspaper articles make veiled allusions to him, he is caricatured in the movies They may be delusions of persecution in which his mail is withheld or tampered with, he is discriminated against by employers or supervisors, he is prevented from getting a job, or his rights are otherwise interfered with, he is watched and followed and accused of things he never did. He may hear people talking about him, accusing him of vile practices, or he may be convinced that he is personally abused and maltreated Again, there may be "delusions of grandeur," in which the hidden belief in his own superiority comes to the fore and he is a great personage, a man who has done notable deeds, he is the heir to a great estate, occasionally he is the President, a prince or a king, or even some dead personage of fame now reincarnated He is the inventor of perpetual-motion machines or of new systems of philosophy or of new religions.

In the hospital the paranoid believes himself to be abused and mistreated He has been "framed" and "railroaded" there It is part of a plot to get rid of him, to obtain the money due him, to steal his inventions or to keep him from exposing the iniquity in high places He threatens to sue the superintendent, he frequently does sue out writs of *habeas corpus* He may assault others in his environment—doctors, nurses, attendants, even other patients—because he believes them to be part of the plot against him He writes numerous letters to officials, going into minute detail about his persecutions and his own deserts. He is likely to be a difficult patient to care for, even if he does nothing more than complain about the hospital and his detention there.

The milder cases, however, may content themselves with working out their inventions or their systems of philosophy, at the same time being very useful about the institution The writer of this chapter never has forgotten the first case of the kind she ever saw, many years ago. He was the head baker in a large State hospital,

who, when his bread and cakes had been sufficiently admired, took us into his office to show us drawings and specifications for a perpetual-motion machine He was merely working in the hospital, he explained, until he had obtained some very delicate parts that had to be imported from a foreign country, then his machine would entitle him to recognition as the greatest physicist in the world. He used technical terms and mathematical formulas quite over the head of a college student and spoke familiarly of world-famous physicists. Not until we had left the building did the guide explain that the head baker was a patient.

TYPES OF PARANOID REACTIONS

There are several different types of this disorder, the classification usually being into *true paranoia, paranoid state or condition,* and *paranoid dementia praecox* The latter we have already considered in a previous chapter The peculiar paranoia of chronic alcoholism has also been treated previously (p. 90). They all have in common the delusions of persecution and mistreatment, or the belief in their own superiority, and often both.

True Paranoia

The true paranoiacs are not often found in hospitals. They are so clever in argument and inference, so convincing in their stories that most people, even if they do not believe them, at least cannot refute them If they do get into hospitals they soon get out by an appeal to the court. Judges and juries practically never commit them, and most normal people cannot be convinced that they are mentally irresponsible.

Dr Mary T is a brilliant teacher of mathematics Now fifty-five years of age, she never has held a position at all commensurate with her ability, but has published several texts that have had wide sale at first, though other mathematicians find peculiar flaws in them When these are pointed out in reviews she always replies with intricate examples and solutions to prove that she is right Nothing pleases her more than a long-drawn-out controversy, from which one opponent at least withdrew with the private remark that the woman was either a consummate genius or crazy, and he really did not know which.

Dr T 's professional life has been greatly complicated by her

personal one, and both have been stormy. Her first position was in a small college, where the Dean of Women welcomed her and made much of her However, she soon began to feel that the other teachers were jealous of her and found numerous reasons for her suspicions. She made friends with certain of her students and began to hint to them of some of the things that she was enduring The Dean, who seemed so nice to her, she said, was really covering up an attitude of great antagonism because she had wanted her niece to have her position, the Dean was making it difficult for her in many ways Other teachers slighted her and copied her work She was attractive and could be very gracious and also very feminine More than one student found her in tears at various times The tension in the department grew, and no one seemed to know quite what was causing it Before the year ended two teachers had resigned and Dr T was boasting that soon she would be head of the department The Dean had been asked by the same niece (who, Dr T declared, had wanted her position) to be nice to Dr T. because she had had such a difficult time in college with students who were jealous of her brilliant work; the Dean began to wonder what it all meant, but Dr T saved the situation by accepting another position

Here, for some reason, she attached herself to the head of the department She never got on well with men, but Professor H , who was growing old, was greatly intrigued by her mathematical ability and flattered by her open admiration Soon she began telling certain students of his dependence upon her, of problems she was solving for him and papers she was writing. Soon she threw out hints that Mrs H was jealous of her, and one evening when a student went to call on her she found the door locked, and it was not opened until the student had identified herself Then Dr T explained that Mrs H had been so disagreeable to her that she lived in perpetual fear of her attempting to force her way into the room and say things to her that she could not endure In a burst of confidence she said how foolish it all was, as she herself was soon to be married She showed the girl her trousseau and her fiance's portrait.

Things went on much the same as in her first position; continual turmoil prevailed in the department; some teachers felt that Dr. T. was stirring up strife, while others defended her Professor H himself stood by her, although the stories about Mrs H. continued to circulate. When the tension at last grew too great to be ignored, she was summoned before a faculty meeting, where she de-

fended herself so skillfully that most of the members merely felt bewildered over the situation and expressed themselves as unable to decide where the difficulty lay Dr T. had led them to infer that it lay with another member of the department, and this man resigned in great bitterness over the situation, but felt helpless to do anything about it

The rest of the year Dr. T moved more cautiously, but the second year her "persecutions" by her fellow workers and especially by Mrs H became more pronounced, and this time the president, having looked into her previous record, forced her to resign

The story has been the same in many different positions Her marriage never came off, although several times she has announced its imminence Positions became harder and harder to secure, and she was finally reduced to tutoring, however, she has frequently been able to find friends who believe in her and assist her for a time, until she takes them into her delusional system and trouble ensues. These friends are always women, with some of them she has a highly emotional relationship, but she never has been able to establish an enduring friendship with anyone

Dr T exemplifies the type of paranoid person who is practically never recognized as mentally unbalanced Such people go through life as trouble-makers, yet they always find champions Whereas most people believed this woman was willfully "mean and hateful," there were always those who felt sorry for her and believed her tales of persecution In a court of law it would be impossible to prove that she had done more than stir up some strife, if even that much could be shown to be true. Yet her closest acquaintances knew that she believed herself to be one of the great mathematicians of all time, and that she felt she was forever defending herself against plots to defame her.

Paranoid States or Conditions

These are more easily recognized as abnormal mental conditions. The delusions are not so well systematized or worked out and are likely to have a bizaire nature about them that strikes the layman as "crazy." However, the fact that in many cases they can cover their delusions and give logical explanations for their conduct makes these people difficult to commit to an institution They may go on for several years cherishing the most absurd delusions without anyone's finding it out.

Gregory M. was a petty officer with several years' service in the Navy, known for his devotion to duty and for his rigorous adherence to certain routines He was a silent sort who had few friends and no buddies. He surprised his superior officer one day by appearing before him and demanding that his rating be raised, declaring that he was being discriminated against and threatening to take his case "higher up" if his demands were not complied with The officer, realizing that something had gone wrong, talked to him calmly, Gregory became less tense, but poured out a long story of mistreatment at the hands of "certain parties" who put vile thoughts into his head and induced his shipmates to call him names—"the worst names you could call a man, Sir, trying to make out I'm too dirty to live." This had been going on, he said, for at least two years and was becoming so bad he could stand it no longer If the Navy could do nothing he might have to do something about it himself.

He was sent to Sick Bay (the ship's hospital) where he lapsed into silence, absolutely refusing to say anything to the doctor except "You know all about it, you're one of 'em" He remained quietly in Sick Bay during the voyage, amusing himself with crossword puzzles and refusing to do any work. Through the usual channels, he finally arrived at Saint Elizabeths Hospital.

Here for awhile he was pleasant and superficially co-operative The physical examination revealed that he had had syphilis years before, and many of his delusions were built around this fact He believed that everybody knew he had had "a bad disease" and that people shunned him for this reason When he passed two or three people talking together he knew they were telling each other about it Voices called him sexual epithets, though he was not yet able to determine whose voices they were He was an intelligent man, passing tests at a high level, though his schooling had stopped at the eighth grade "I wanted to go to high school and college," he said, "but my dad was a drunkard and I had to go to work I never got a square deal at home and I got out as soon as I could" He had been estranged from his family for many years, running away from home and going to sea at sixteen The Red Cross located a sister, who was considerably younger and could not give much information She knew, however, that Gregory had been a difficult child, surly and grouchy, "always had a chip on his shoulder" He was bright in school, but did not get on well with either teachers or pupils The father, though he drank occasionally, was not a drunkard, but "Gregory was a good deal like him. The father was hard

to live with, though he was a good provider and a respected member of the community" The other children were all apparently normal and well adjusted

For some time Mr M. adjusted himself fairly well in the hospital, then he began to grow more tense and suspicious and passed through a stage of excitement in which he became ugly, threatening and finally assaultive. He had to be watched carefully for several months. Gradually he became quieter and less tense and was allowed some privileges In an unguarded moment at the movies he eluded the attendant and succeeded in getting some distance out into Maryland before he was apprehended After his return he started writing letters to judges, prominent business men, senators, and so on, complaining of his illegal detention He never had been committed since he had no legal residence in the District of Columbia He now began demanding to be taken to court, as under the law he had a right to do Here he insisted on taking the stand and told such a bizarre story of his persecutions that the jury unanimously declared him of unsound mind and he was committed.

For a while Mr M. seemed to be much better, saying that now his story had reached the ears of the law and he would get redress sooner or later Then again he became worse, tormented by the voices and believing that people came into his room at night and misused him sexually In the six years that he has been at the hospital the excited attacks have grown less frequent, and two or three times he has been able to enjoy ground parole He still believes his delusions and hallucinations, but much of the time they do not worry him very much He seldom associates with other patients, but occupies his time reading, writing innumerable letters, and typing for one of the doctors. In casual conversation he is courteous, intelligent, well versed in current events and exhibits a well-preserved personality

Other Paranoid Conditions

There is a type of paranoid personality, met more or less often, referred to as *litigious,* because the person is always appealing to the law He spends his time suing people and getting involved in litigation He suffers a real or fancied injustice (usually the latter) such as being cheated in a property deal, losing money in speculation, or being injured in an accident Thereupon he "goes to law," but he is never satisfied with the court's decisions. Even if a case

is decided in his favor, he picks flaws in it and tries to have it reopened He likes to be his own lawyer and plead his case at length If he has money, he spends it in lawsuits, if he has none, he is always attempting to get lawyers to take his case, promising them riches when it is won, or trying in some other way to get justice Occasionally he attempts assault or blackmail or some other form of extortion. He may reach the hospital through the prison route, or because he becomes an intolerable nuisance to family or friends There he usually can conceal his ideas and rationalize his behavior to such an extent that it is difficult to prove to a jury of laymen that he is really an irresponsible person He seldom becomes a hospital resident for any length of time

Milder paranoid states and "paranoid flurries" occur during the course of other psychoses, in the neuroses, and even in normal people under great physical or emotional stress Paranoid ideas are common in the neuroses and the psychoses of middle life and old age, we have dealt with some of them in Chapter 8 They are common also in children, who are prone to blame others for their own shortcomings, and are easily stirred to jealousy and suspicion It must be emphasized that a few or transitory paranoid ideas do not make a paranoiac, not many of us are free of them for an entire lifetime It is the fixity and the permanence of the delusions, and the type of personality that harbors them that are the criteria of the condition

Paranoid persons are usually regarded as potentially dangerous, though many mild cases live their lives in a sort of compensatory dream and disturb no one Many religionists are of this type, and religious fanatics in general are perhaps best understood as paranoid personalities; so are the pseudophilosophers whose works are too involved and abstruse to be understood by ordinary mortals Religions have been founded before now by paranoiacs who believed devoutly in their visions and revelations and were able to inspire others with belief in them also Systems of thought—economic, political, or otherwise—have been put forward by paranoid thinkers and philosophers, and groups of people or even whole nations have found themselves bogged down in them, as Germany so recently has been Poets, artists and musicians have been paranoiacs or paranoid personalities, sometimes suffering actual breakdowns and afterward being able to drain off their paranoid ideas again in their works If we remember that the paranoid personality is unable to deal with reality in its often stark brutality and must build up

ideas that are a defense against it, it will be easier to understand the above statements.

Brickner* would have everybody taught in school the principles of paranoid behavior. He coins the name "paranee" for the paranoid's victim—the object of his projections—and believes that the only way to prevent people from becoming "paranees" is to inform them fully, early in life, as to the paranoid's behavior and the personality that is prompting it

Brickner is concerned not only with the paranoid individual but with groups that are actuated by paranoid attitudes Of these groups Germany certainly is the star example; but smaller groups are dominated by these attitudes, some of them in our own country. Whenever a group is bound together, not by a common interest in science, art, politics, nature, entertainment and the like, but by a belief in its own superiority, we face the danger at least of group paranoid behavior Thus we have the persecutions of minority groups on the pretense that these people are inferior, plotting against the superior types, and must be driven out or exterminated Groups may be bound together by their hatred of persons or of ideas, believing that their own superiority is threatened by them, and finding many plausible reasons to prove their fears well founded "Groups like this," says Brickner,† "show in their utterances and the actions of their leaders, and of their individual constituents when acting as a member of the group, the typical paranoid phenomena of the total constellation—megalomania [delusions of greatness], suspiciousness, sense of mission, sense of persecution, marked projection and extensive rationalization" Such a group may give free rein to its aggressive and destructive impulses, performing atrocious deeds which it justifies as necessary for its own protection or that of the Constitution, Americanism, decency, honor, and so on

If the average person really did know a paranoid reaction when he saw one, we probably would have fewer of these paranoid groups, which are a plague to every democracy, as well as fewer "paranees" who would permit their lives to be made miserable by their paranoid friends and relatives. As Brickner suggests, it might even be impossible to put over on the world such a hoax as Germany played from 1937 to 1939, for we all would understand that you cannot appease a paranoid any more than you can hope to cure his twisted ideas by reasoning with him.

* Brickner, Richard Max The paranoid, Am J Orthopsychiatry, **13**:400, 1943.
† *Op cit.*, p 403

TREATMENT

All this sounds quite hopeless from the standpoint of therapy, and it is The paranoid's excellent intelligence and the fact that he maintains his personality organization, so that in many respects he appears like a normal person, would suggest that he ought to profit from psychotherapy; but his fanatical belief in his own rightness and the absolute rigidity of his make-up prevent his doing so Henderson and Gillespie state that not more than half a dozen cases for whom successful treatment is claimed "with a show of justification" ever have been reported.*

It is true, however, that some cases improve to a certain extent if life becomes easier and stresses are removed. Illness or old age sometimes lessens their drive, so that such patients become easier to care for In other cases, aging breaks down what self-control has been established, and the person is more instead of less suspicious, persecuted and hating or convinced of his own greatness.

How does one recognize the types that are likely to be dangerous? If the true paranoiacs cannot be placed in hospitals, how can they be dealt with? Those psychiatrists who contend that paranoids are always *potentially* dangerous are probably right, even though the majority never become assaultive. The paranoid's ability to keep his thoughts to himself until they get too much for him, as in the case of Gregory M, makes it impossible to predict that a certain person may or may not ever be dangerous Both the silent, taciturn, brooding people and also those who are suave and pleasant enough until their delusional system is touched upon may decide to take the law into their own hands.

Every psychiatrist knows paranoid persons who have assaulted and sometimes killed people who had no personal relations with them An attendant in a hospital, dismissed for neglect of his patients, made his way to the office of the superintendent and shot and killed him, blaming him for a long series of persecutions A patient who had left the hospital on a writ of *habeas corpus* went to the West Coast and lived inconspicuously for several months Then one day, while driving on a crowded street in the city, he leaned out of the car and shot a man in a car that was passing. This man, he explained, was the head of the gang that kept following and persecuting him It was proved that the man was an utter stranger to him. In this case, the physicians at the hospital knew that the pa-

* Henderson, D K, and R D Gillespie A Textbook of Psychiatry, ed. 6, New York, Oxford, 1944, p 379.

tient was dangerous. He had been assaultive and once before had attempted to kill a man whom he identified as "the head of the gang." However, the jury of laymen, confronted by the fine-looking, suave gentleman who had plausible answers to everything the doctors could say about him, felt that if he ever had been psychotic he must now be recovered. Thus there came about the death of an entirely innocent man.

The majority of paranoids, however, confine their assaults to words The persons who happen to be the objects of their projections are accused, brow-beaten and subjected to torrents of abuse. If they fight back, it is used as more proof of their perfidy and their mistreatment of the paranoid Nor is it always easy to get rid of them· once having become involved with a paranoid, the "paranee" usually finds it difficult to escape

The milder cases, who are less tense and full of hate, whose energy expends itself largely in the creation of philosophies or inventions or grandiose schemes, are not so likely to be physically dangerous But they, too, are likely to be difficult to live with, full of changing moods, morose or ugly tempered, or given to outbursts of passion.

As to the true paranoiacs, such as Dr Mary T , the best way to deal with them is to avoid having any dealings with them so far as possible. Since they are invariably highly intelligent and often attractive persons who know how to impress others, they always succeed in making friends who believe in them implicitly, but they have no scruples in tossing to the lions those same sympathizers after they have served the paranoid's purposes Although the damage they do may be confined to feelings, dispositions and reputations, it may be very great, and if they get into positions of power and authority they may do incalculable damage, both physical and moral. If, as Brickner says, normal people could be taught early in life the symptoms and the principles of paranoid behavior, the paranoiacs might at least be "walled off" from the rest of us and would have little opportunity to use their favorite weapons against us.

How early in life can a paranoid personality be recognized? What should a parent do if he suspects that he has a paranoid child? From the histories of our patients and from the few cases that have been observed since childhood, it seems possible to recognize the beginnings of paranoia in adolescence, even though it does not come to full bloom until fairly late. We see adolescents

who are sulky and disagreeable; who get on poorly with their associates and absolutely refuse to take any blame, always shifting it upon others, who are arrogant and self-important, yet oversensitive, quick to see slights and insults where none were intended A certain rigidity about them makes compromise impossible, one must always meet their terms They insist that they are never understood, and they usually are disliked by their fellow adolescents

Some of these characteristics may be evident in milder form even in childhood, though we must remember that most paranoid traits, especially jealousy and the desire to shift blame, are common enough in children. It has been suggested that the trouble arises when they are not outgrown but fixed as elements of the character. In this, parents have the responsibility of helping the child to face reality and to take the consequences of his own behavior. Parents who themselves are fairly normal and well adjusted and can give the child understanding love and a stable home need have little fear of his developing into a case of paranoia Back of paranoia, no matter how grandiose and egoistic the person may be, are always insecurity and fear, those two great devils of childhood. Our paranoid patients, in the majority of cases, come out of homes that rejected or neglected them or failed to meet their need for love and understanding In this fact, perhaps, lies the answer as to what to do for the child suspected of a paranoid make-up.

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12

The Psychoneuroses

So far we have been discussing, for the most part, the actual mental illnesses, the breakdowns of the personality in which the individual no longer sees reality as others do and feels and acts differently. He has become psychotic or, in legal terminology, he is "insane," no longer possessing a sound mind We now turn to other disorders of the personality in which the person may suffer acutely and may show the most varied symptoms, some of them very peculiar, and yet at the same time not lose his contact with reality He knows there is *something wrong with him, even though he has no* idea what it may be. He is in constant conflict with himself Though he may attribute the cause to other people or to the circumstances of his environment, he realizes that the struggle lies within himself Dr Nolan D. C. Lewis has put the matter neatly by saying that the neurotic fights himself, the psychopath (whom we shall meet in the next chapter) fights society, while the psychotic has given up the struggle

If the actual psychoses are comparatively numerous, the neurotic conditions are more numerous still Various authorities estimate that from 30 to 50 per cent of the average doctor's practice is composed of sufferers from such conditions. We all know persons who have neuroses, many of us suffer from them in greater or lesser degree We might describe a neurosis as a functional nervous condition (functional in the sense of *not being caused by a known* physical condition) more or less severe, which, in a greater or lesser degree, prevents the sufferer from making a happy and successful adjustment to life. We have to remember that happiness is a rela-

tive term, and that in our present stage of evolution no one can expect to escape much unhappiness. Yet the really normal personality, while experiencing periods of grief and unhappiness and frustration, still has within himself a power to cope with life and to face and overcome its disasters so far as is humanly possible. This sense of power and adequacy the neurotic does not have No matter how hard he struggles, he lies at the mercy of his inner conflicts

In the majority of neurotic conditions, the milder neurotic states, the sufferers are not necessarily incapacitated They may be capable of good work, even great work, but they are unhappy and dissatisfied, aware that something is wrong but unable to find it Very often they think it is physical, and they may have all manner of complaints seek out one doctor after another, or resort to operations if anyone can be found to perform them If the doctor bluntly tells them there is nothing wrong physically, they feel highly incensed and spread the news of his incompetence They are helped so long as they have faith in a particular doctor, or their inner conflicts do not get too unbearable The doctor calls them hypochondriacs and does the best he can for them If he suggests a psychiatrist, they are greatly upset, since they are convinced that their trouble is wholly physical They are converts to new religions, especially the healing cults, always seeking something that will "cure" them. In industry they constitute the "absentees" who are always losing time because of illness. In the home they are chronic complainers, suffering from all sorts of aches and pains and "nervous spells," unable to take their full share of responsibility, though frequently enough they outlive the healthier members of their families

Others of the "mild neurotics" are the chronic worriers, the anxious people who go through life with puckered brows or lie awake nights to fret over things that never happen. They may be full of fears, afraid of storms, or burglars, of cats or mice or a dozen and one things that are not likely to harm them. Sometimes these fears amount to real phobias, so that a person becomes ill at the sight of a cat, is unable to walk across a street alone, or to drive his car through a tunnel Such phobias are very numerous and cannot be cured by making fun of them, or by forcing the sufferer into a situation where he must face the object of his fear; the latter heroic treatment is likely to result in a "hysterical" attack or a fainting spell.

Many people suffer from a fear of failure, which prevents their doing many things they really would like to do Stage-fright is one

variety of this, as is the fear of examinations or of applying for positions, where one must be interviewed and make a good impression.

The mild depressions, which we have already noted in the preceding chapter, in which the person may be in much mental distress but still retains his grasp upon reality, are perhaps best understood as psychoneuroses Such people may be able to go on with their work, in spite of subjective feelings of disability and mental anguish The psychiatrist also speaks of a "paranoid personality," in which there are oversensitiveness and fearfulness for one's prestige or position, a constant tendency to belittle others, a belief in one's innate superiority which shows itself in "grouchiness" and irritability or hurt feelings. Here again are symptoms of inner conflict, though the sufferer has not reached, and may never reach the stage of true psychosis

We meet these neurotic personalities at every turn They are our friends and neighbors, or perhaps members of our families We find them in all walks of life, from the highest to the lowest, they exist among the upright, as well as among delinquents and criminals. Their symptoms and behavior are best understood as attempts to solve their inner conflicts, though they themselves seldom feel conscious of the true nature of their difficulties They are the people who, though poorly adjusted to life, yet manage to get through it some way or other.

When the psychiatrist speaks of *psychoneuroses* or *neuroses*, he means the much more severe cases, whose symptoms may be similar to those we have been discussing, but they have developed to a degree that actively interferes with the person's adjustment The term *psychoneurosis* implies a "nervous" disorder of psychogenic origin —that is, arising from mental processes rather than physical causes. The experiences with "shell-shocked" cases in World War I and with "combat fatigue" more recently convinced the medical profession in general of the psychogenic origin of these conditions. Many of the shell-shocked cases were not injured physically, yet they were blind or deaf, unable to speak or move, and they recovered without physical treatment, but under various forms of psychotherapy

The symptoms in the psychoneuroses may involve any organ or function of the body. They may be sensory, such as aches and pains, palpitation, a sense of weakness or fatigue, an inability to feel heat or cold, pinpricks, and so on; on the other hand, there may be an extreme sensitivity to stimulation They may be motor, such

as paralyses, tremors, tics, or mutism (the inability to speak or even to make sounds). They may be visceral, as vomiting, diarrhea, constipation, excessive perspiration. Again, they may be mostly mental, as fears and anxieties, loss of memory, trances and sleep-walking, obsessive thoughts, or compulsions to perform acts which the patient may not wish to do in the least All the symptoms do not appear in any one case, they group themselves so that the psychiatrist can speak of different types of psychoneuroses as he does of different types of psychoses

TYPES OF PSYCHONEUROSES

Anxiety

The most common of the severe psychoneurotic manifestations is anxiety In the sense in which the psychiatrist uses it, anxiety means morbid fear The sufferer from an anxiety state may—and usually does—produce both physical and mental symptoms The following is an example of an anxiety state.

Mr. A. E, a government employee of twenty-nine, consulted the psychiatrist about his difficulty in doing his work He had missed out on a promotion because of a low efficiency rating and claimed to be very much upset by this fact. An hour's interview brought out the following catalogue of symptoms he suffered from dizziness, an upset stomach, constipation, "smothering spells" in which he thought he was going to die, from fear of his boss, fear that his fellow workers would find out that he was "no good," fear of losing his job and being unable to find another one (This occurred during the depression when jobs were scarce) He complained of being unable to concentrate, of lack of interest in his work, and of a growing depression All of these symptoms had led him to fear that he was losing his mind, he had used up both his sick leave and vacation time, and was on the verge of what he called a nervous collapse

A. E had been a hard-working and studious boy, finishing college and obtaining a master's degree largely through his own efforts. His father had died in a heart attack when A E was twelve years old. The mother was a "chronic worrier," and he himself always had been a serious fellow, inclined to think a great deal about himself and his troubles He never had had time for social activities, and felt that he might be "different" from other men. He wondered if he

were sexually normal. He never had been in love with a girl, although he would like to marry and have children. His neurosis had been precipitated when, several months earlier, he had read a book on sex and began to wonder if he were not a homosexual The matter had taken hold of him to such an extent that he became sleepless, lost his appetite and could not apply himself to his work. He was even beginning to feel a compulsion to suicide He feared that his boss and his fellow workers recognized his abnormality.

This case was rather typical of anxiety states in general A E. came out of an unstable home, where the illness of the father and an overanxious and worrying mother had given him much anxiety even in childhood. He had been unable to outgrow his habit of worrying, though he had kept his worries largely to himself. In spite of his master's degree he was very ignorant about human nature, and what he learned about sex he had been unable to assimilate

Mr L Y was a different type of case, in which alcohol complicated the neurosis He was the youngest of several children of well-to-do parents, who lived to ripe old age After going through college and professional school, he became a consulting engineer to a large mining concern. He seemed to have a brilliant career before him. However, he began to drink and to neglect his work, and for ten years his family spent a great deal of money upon him without being able to help him for any length of time He was in and out of institutions, took all kinds of "cures" for alcoholism and consulted various doctors He finally attempted suicide and was then sent to a private mental hospital, where he was promptly diagnosed as not insane and recommended to the psychotherapist

From the beginning of treatment Mr Y showed extreme anxiety He would pace the floor for an hour before the period of his appointment, would sit in the doctor's office with perspiration streaming down his face and off his hands, with staring eyes, the picture of acute distress He would plead for alcohol: "Doctor, if only I can have a drink—just a little one—I can't talk without it —I'm so nervous—so frightened—I want to get well—do you know what's the matter with me?—I'm insane, ain't I?"

Mr. Y always had suffered from feelings of insecurity and inferiority, though during his childhood and youth he had been able to handle them Not until after his marriage did the real break come. During his engagement he had discovered that the girl was having an affair with another man and he became much upset by

the knowledge, but he hastened the marriage instead of breaking the engagement. At this time he had felt very big and forgiving, very protective of the girl, and anticipated a happy married life But he soon began to have obsessive doubts, not of the wife but of himself. He began to fear that there was something wrong with him He was evidently not the kind of man who could attract and hold a woman. He began to suffer from insomnia, could not concentrate on his work, felt that he lacked the needed intelligence and training to hold his position. He developed severe headaches, indigestion and colitis He began drinking to buck himself up, and soon came to depend upon alcohol to keep himself going. He became more and more concerned about himself and his inadequacies, developed more physical difficulties and consulted numerous doctors. He had anxiety attacks at night in which he perspired profusely, his heart palpitated wildly, and he felt that some terrible thing was about to happen to him By this time his wife had left him, and he had consciously forgotten his original difficulties with her

Both these cases received psychotherapy, and both responded fairly well A. E.'s case was comparatively simple, but Mr Y 's was much more deeply seated and required many months of intensive treatment The physical symptoms were taken at their face value, but in both cases the physical symptoms cleared up as the emotional difficulties were straightened out.

Anxiety attacks occur in other psychoneuroses and in the psychoses, and states of panic may be found in both mental and physical illness They were probably the most frequent manifestation among the numerous cases of psychoneuroses occurring in servicemen during World War II They also frequently occur in women at the menopause, even in healthy women who have few other symptoms, and they are especially common in children According to the Freudians, the cause of anxiety always lies in the sexual sphere. Other psychiatrists find the causes in mental conflicts over many other things as well as sexual matters, occurring in a personality that is emotionally unstable and given to worrying Often there is a neurotic heredity, and more often the person is the product of a neurotic family, more especially perhaps of a neurotic mother.

Neurasthenia

A generation ago the diagnosis of neurasthenia was made much more frequently than it is now, though the layman is still inclined

to think of states of depression as "nervous exhaustion" or "neurasthenia." In its pure form, according to Adolf Meyer, neurasthenia consists of inordinate mental and physical fatigue with sensations of pressure in the head, and the patient complains of poor memory, inability to concentrate, irritability, sleeplessness and vague aches and pains The pure form is seldom found nowadays. There appear to be fashions in neuroses, as well as in ideas and theories

There are a good many people, however, in whom fatigue is an outstanding complaint, without any physical basis for it

Miss T. R , a graduate student, aged twenty-five, consulted the college physician because of extreme exhaustion, headaches and nervousness. As the doctor found no physical basis for her complaints, he referred her to a psychiatrist. Miss R. refused to see her at first, indignantly denying that she was "insane", but as she felt herself growing worse she finally went for consultation

Miss R had had a long series of ups and downs. She had been a delicate child, carefully brought up by an oversolicitous mother who seldom let her out of sight. In college she had had a diagnosis of tuberculosis and had spent a year in bed After graduation she had worked as a secretary, and in addition had taken on the secretaryship of an organization that required a considerable amount of extra work She had kept up this work when she went back to college. She described herself as "always a nervous type," closely attached to her mother, who was ambitious for her to become the head of a business school, as she herself had been before her marriage. Miss R had heard much all her life concerning the advantages of a business career over marriage. However, during this school year she had met a man with whom she fell in love and wished to marry. The conflict set up in her mind between her desire to please her mother and her own wish for marriage proved to be too much for her, but she herself was unaware of the existence of the conflict. She had broken with the young man and resolutely put him out of her mind, believing that she had made a wise decision, and kept bending all her energies to prepare herself for her future career Then she began to suffer from headaches and to feel too fatigued to continue her work She and her mother were both convinced that overwork had caused her breakdown.

Miss R 's case was not a simple one. It was complicated by her relationship to her mother and by her own infantilism. She could not grow up and relapsed into invalidism, thus denying her own

wishes while at the same time being unable to carry out her mother's plans for her.

Hysteria

The layman conceives of the hysterical person as one who is highly emotional, who gets greatly upset or confused and is unable to behave rationally in a crisis, who is tense and screaming, or laughing and crying at the same time But this is not the psychiatrist's idea of hysteria. As Zilboorg* puts it, " . . . the old-fashioned hysteria of the popular mind is . . . brief, acute, it usually appears as a severe reaction to a sudden emotional shock, and it wears off, if not suddenly, at least rapidly, it is the old-fashioned temper tantrum emerging in a more respectable, pseudoadult, sentimentalized atmosphere The real hysteric, the one who has definite symptoms of obscure psychological origin, may feel considerable discomfort on occasion, but he usually displays an extraordinary equanimity This is so striking a characteristic of such patients that the leading French authority on the subject, Janet, was prompted to speak of *la belle indifférence des hystériques*"

The term *hysteria* is derived from the Greek word for uterus and from ancient times was believed to be caused from the wanderings of that organ, which was thought not to be fixed in the pelvis but inclined to slip its moorings and wander about over the body, causing all sorts of peculiar behavior Thus hysteria was confined to women, and long after the "wandering uterus" theory was known to be false, doctors continued to believe that no man could suffer from hysteria. When in 1890 Freud wished to present the case of a male hysteric to the Vienna Medical Society, he was greeted with ridicule and laughter. Everybody in those days "knew" that hysteria was a woman's disease. Today we know that any hysterical symptom can be presented by either sex

Hysteria also seems to be falling out of fashion in many quarters It was very common in World War I, and Mira† states that the "core of the overwhelming majority of war neuroses is constituted by conversion hysteria," referring to his experience in the Spanish Civil War In the recent war it was far less common, and in the intervening years it had largely died out in England In this

* Zilboorg, Gregory Mind, Medicine and Man, New York, Harcourt, 1943, p. 130

† Mira, Emilio. Psychiatry in War, New York, Norton, 1943, p. 83.

country it is not diagnosed so frequently as formerly, although it still flourishes in certain sections of the country and in certain strata of society We might infer from this that hysteria is a disease of the ignorant and the misinformed, and to a certain extent this is true It was the mental illness above all others in the Middle Ages, when people were ignorant and superstitious, and knew little about their bodies and nothing at all about their minds. The medical history of the times is full of witches, of devil possession, of dancing manias and of all kinds of peculiar behavior that we should recognize today as the manifestations of hysteria

The chief characteristic of hysteria is conversion—the changing of an idea, which for some reason is unacceptable to the person involved, into a physical symptom During World War I the idea was often associated with cowardice The soldier could not bear this idea, but if he became physically incapacitated, blind, mute, or paralyzed he need not feel himself a coward He had a means of escape and at the same time a means of "saving face," as it were

Hysterical conversion may involve any organ or function of the body There are few of us who do not make use of the "conversion mechanism" at one time or another. Headaches, stomach upsets, asthmatic attacks and other minor illnesses serve the purpose of helping us get our own way, of securing attention or escaping from disagreeable situations. These things are not by any means faked, hysterical pains are real pains, and an asthmatic attack brought on by an emotional upset is as uncomfortable as though it were due to a real allergy But apparently they are less painful or uncomfortable than what one would have to endure if one faced the idea that lies back of them.

Mrs. M G, a comely woman of thirty-six, has lain in bed for four and a half years, because when she attempts to rise she gets a violent palpitation of the heart and fears that she is going to die. She has various other aches and pains, but it is the heart condition of which she complains most Mrs. G is the wife of a small farmer in the Southwest. She had three living children and had lost several. She had to do much hard work, and on one occasion after doing a big washing on a hot day she collapsed in a fainting attack A doctor was called; he said she had a weak heart and must not do any more washings He put her to bed for a rest From that day to this Mrs G has stayed in bed, convinced that to get up would mean her death. Several doctors have examined her and tried to convince her that her heart is perfectly normal, but to no avail. In the mean-

time she has put on twenty pounds and appears to be in the pink of condition, except, of course, that her muscles are flabby from disuse.

What could induce a young and apparently healthy woman to behave like this? Mrs. G was an only child, much pampered and spoiled. She married at nineteen and had numerous pregnancies, which her religion forbade her to do anything about Her illness has enabled her to be a spoiled and pampered child again, her mother moving in and taking charge of the household It has enabled her to refuse sex relations, so there have been no more pregnancies In her mind she is conscious of none of this She believes that she is really sick, has frequent heart attacks, and periodically gets the family up at night, children and all, to see her die.

The cases of blindness, deafness, mutism, or paralysis are more striking to the observer Recently a twelve-year-old girl was brought to one of us, with a history of "spells" in which she became totally blind and could not see for hours at a time She had been treated by a "Mexican doctor" who said she was bewitched The family had accepted this diagnosis, and two other children began to act peculiarly. An older brother developed pains around his waist and displayed reddened and discharging eyes A nine-year-old sister went to bed and refused to eat, becoming greatly emaciated. The girl herself, sent into a hospital for observation because the attacks that preceded the blindness were suspected of being epileptic in nature, developed hallucinations and saw a bird on her window sill which turned into a big black dog and talked to her When she went home, the dog followed her, and her mother also saw him, with a light between his eyes "like a headlight"

The suggestibility which this family shows is characteristic of the hysterical personality and, we might add, of children in general Perhaps for this reason children are prone to hysterical reactions, and often enough it is difficult for even the physician to differentiate an actual illness in a child from an hysterical one.

Among the most striking of the hysterical symptoms are the fugues, the trances and the somnambulisms of which we occasionally hear or read In a fugue a person does things for which he has no memory afterward (unless he can be induced to remember by special psychologic methods) A friend of one of us did not come home from work one night, nor could he be located for several days. Then he telephoned from Buffalo to his home in Albany and returned the next day. He explained that he had found himself in

the railroad station at Buffalo, with no knowledge whatever of how he got there. Mr. X. was a highly nervous person, who had lately been worrying over financial reverses and his wife's health.

Trances are often feigned by mediums, spiritualists, and others of their kind, but they actually occur in hysterical people, especially under strong excitement or emotional shock Somnambulism, or sleepwalking, is common in children and occurs in hysterical adults also. Sometimes a vivid dream is acted out The writer of this chapter well remembers an episode of many years ago, when she was a young teacher in a country community in the Middle West. A sixteen-year-old boy left his home in his night clothes on a bitter winter night and ran to the nearest neighbor's a half-mile away He wakened the family, who brought him into the house, where he told them that a man had broken into his home and murdered his father and mother and set fire to the house In the midst of his story he suddenly awoke, terrified and bewildered, and began sobbing in relief when he could be convinced that it was only a dream.

The cases of dual and multiple personality that are occasionally exploited in the newspapers are examples of "hysterical dissociation" The patient's personality is split into two and sometimes more parts, each one appearing as a whole personality and behaving as though it were the actual person himself. This is not so difficult to understand when we remember that each one of us has different "selves," in relation to our occupation, our families, or certain of our friends. It is not uncommon to hear it said, "So-and-so is a totally different person when he is in such-and-such a situation." But the dual and multiple personalities are cut off completely from the rest of their "selves" and have no knowledge of anything but their present state. The most famous of these is perhaps Dr. Morton Prince's "Sally Beauchamp"* This young woman, a student in Boston, consulted Dr. Prince about some nervous difficulties In the course of this treatment she developed a secondary personality, which was all that Miss Beauchamp was not, mischievous, rather unconventional and much interested in the opposite sex. After several months, one morning a young woman who looked like Miss Beauchamp but was not, walked into Dr. Prince's office with some letters and notes about the case which she had found in her room

* Prince, Morton The Dissociation of a Personality, New York, Longmans, 1906

but of which she had no knowledge whatever So far as she knew, she never had seen the doctor. It developed that she was the real Miss Beauchamp, both the others being secondary personalities

There are also hysterical attacks, which may be fainting spells or attacks that are difficult to differentiate from epilepsy There exist points of difference that the doctor can usually discover by means of special tests, and in general it may be said that such fits are likely to occur when the patient has an audience, and that he "chooses a soft spot on which to fall " The epileptic patient may injure himself severely by falls, but the hysteric rarely does so, and then only by accident It sometimes happens that an epileptic may produce hysterical attacks in addition to his epilepsy. A fifteen-year-old epileptic of our acquaintance used to have attacks in which she went through peculiar movements as though she were fighting somebody and ended by running from her home to some neighbor's and crawling under a bed.

We have by no means exhausted the catalogue of hysterical symptoms and behavior Hysteria can simulate any known disease or condition, physical or mental The hysteric's suggestibility enables him to pick up all kinds of symptoms, without knowing their meaning or their limitations, and so many of them are easily detected by the doctor. In general, it may be said that when an illness can be cured by faith, a mental healer, a witch doctor, or by patent medicines, one may be strongly suspicious of hysteria. Such "cures" are seldom permanent The patient may lose his tic or his limp, his paralysis or his heart trouble, but he retains his personality, when mental stress again arises, he produces more symptoms, sometimes the former ones, more often new ones that are more suited to his present situation. Again, we must emphasize that the hysteric is not a pretender He has no knowledge of why he is sick or disabled; he only knows that he is, and he accepts it cheerfully enough as his unhappy fate

Much has been written about the hysterical personality Its most striking feature is the tendency to dissociation, which we have been discussing, but other features are common. The patient may appear very emotional, but he really has no deep feeling A hysterical woman will weep violently, faint and give other evidence of great grief at the death of her husband, only to wipe her eyes and begin to look about for another one The hysteric probably loves no one so well as himself He frequently impresses others as acting a part and to be producing symptoms to gain attention and sympathy.

As a rule he takes life easily and is an adept at getting out of things he does not want to do. These are childish traits, and the hysteric is in truth a childish personality: he has not learned to deal with the inevitable problems of life on an adult level.

Here, again, we have the probability of hereditary, or at least constitutional, factors playing a part in the production of such a personality, and even more the type of childhood environment that fails to give the child leeway to grow up normally.

Obsessive-Compulsive States

Most normal people have had experience with obsessive thoughts. A tune, a stanza of poetry, or something similar, runs through the mind over and over, sometimes in a very annoying fashion. From this "obsessive thinking" to the obsessional neurosis is quite a step, though the mechanisms are probably the same in both cases. However, the normal person can usually rid himself of his obsessive thoughts without feeling anxious and disturbed about them, not so the obsessional neurotic The harder he tries the more his obsessions persist, or they change into others that are even more difficult to cope with.

Persistent sex imagery and obsessive thoughts of sex are fairly common in adolescence. A few years ago a boy of seventeen consulted the psychologist, in great distress because, as he said, every girl or woman whom he saw he "had to undress in his mind." Along with this obsession went obscene words which shouted themselves over and over in his mind until he was afraid he would be compelled to shout them aloud.

Max turned out to be the only child of a widow, who had brought him up "beautifully," so that only a short time before had he really learned much about sex A friend had taken him to a burlesque show, where he saw a strip-tease act. He became greatly excited and could not get it out of his mind He began imagining how various girls and women of his acquaintance would look in the nude, and found himself unable to stop thinking about the matter What had really happened was the reanimation of some old childish fantasies about his mother, who had punished him severely for peeping at her when she was undressing When his childish behavior had a full airing, Max's obsession disappeared

This is a very simple case In others the mind is continually occupied with thoughts which seem to have no particular interest to

the person, and yet he is compelled to dwell upon them to the exclusion of other matters that should occupy him The indifferent thoughts serve as a screen to keep more unpleasant matters out of mind. The thoughts themselves may be symbolic, so that it is fairly easy to see what they disguise, or they may have undergone several transformations, "displacements" from one thing to another, so that it is very difficult to track down their meaning to the patient.

Obsessive states are closely related to compulsions, and the two are frequently found together, so that the diagnosis likely to be made in severe cases is "obsessive-compulsive neurosis" The obsessive ideas take possession of the patient and issue in a feeling of being compelled to certain acts, as Max was afraid he would be compelled to shout aloud the obscene words in his mind

Mr B J, a student in a teachers' college, visited with his class a clinic at a mental hospital, and was so upset by what he heard that he consulted a psychiatrist B J was twenty-four, a very thin, nervous-appearing young man, who began his story by telling of a compulsion to suicide. For some time he had been afraid to go in swimming for fear he would drown himself He had innumerable fears—of high places, of knives, of revolving doors and escalators He had all sorts of minor compulsions He had to count his steps in going upstairs, to count the panes of glass in every window he saw He was compelled to go through a ritual in going to bed and in getting up If anything was omitted he had to do it all over again In spite of it all he was a good student, wrote poetry, drew and painted very well and, though he was considered peculiar by his fellow students, he was graduating with honors

B J was followed for several years He lost his compulsion to suicide, but developed others He became compulsively clean, had to wash his hands after touching anything that anyone else had touched recently, could not eat without first scalding the dishes, or sit down in a chair without placing his own clean handkerchief in it (he carried a number of them for this purpose). He had obsessive fantasies, one of a young boy being beaten by a brutal woman, another of the "primordial slime," in which, as he said, he had to watch the drama of creation being enacted He developed a compulsive love for his father, who had been dead several years, and visited his grave in a distant state, where for three nights he went through a ritual of penance All this time he was perfectly well aware of the foolish and peculiar nature of his acts, but quite unable to do anything about it. For several years he was able to con-

ceal much of his behavior, holding several other jobs, as a tutor, a Government clerk and a chauffeur. He made desperate efforts to effect a sexual adjustment, but could make no headway with girls, he was in a fair way to establish a liaison with an older woman, but became greatly frightened and ran away from her. There were intervals in which he appeared much better, and he would be almost symptom-free for several weeks at a time Then his obsessions would come back in full force. They came to a climax when his mother, from whom he had been estranged for several years, became ill Now he had a strong compulsion to go to see her, but resisted it In a few weeks the mother died He lost all control of himself, began drinking very heavily, running about over the country to one relative and another and behaving irrationally, though he was well aware of it and greatly distressed by what people must have been thinking of him He finally developed the compulsion to have his mother's body exhumed, that he might look at her once more When he could not get this done through the proper channels, he himself attempted to open the grave, was arrested and, through the intervention of relatives, was finally hospitalized

B J.'s case shows a severe compulsion neurosis in successive stages Such conditions are closely allied with the schizophrenic psychoses and are very difficult to do anything about The young man came from a highly neurotic family The father had drunk heavily and when in his cups was very abusive to his family The mother also had had obsessions and compulsions in her childhood and was always very nervous and a worrier. A brother had been hospitalized, and a sister was under the care of a psychiatrist. B. J 's childhood had been full of fear and greatly lacking in emotional security, though there had been a very close bond between him and his mother As far back as he could remember he had had obsessive fantasies and daydreams and minor compulsions of all sorts, such as always walking on the left side of the street, counting the desks at school, the boards in the floor, the steps of the stairs, washing his hands three times before he ate, saying three prayers for his mother at night and other peculiarities too numerous to mention. He had been a precocious child, led his classes in school and suffered his compulsions in silence.

Here was certainly a bad heredity and a very bad childhood environment The compulsive personality is obstinate and rigid, given to orderliness and cleanliness, sometimes to an exaggerated degree,

and to an interest in petty details, it exists in these people from an early age

CAUSES OF PSYCHONEUROTIC CONDITIONS

The causes of psychoneuroses have been much studied in the last few decades, since they are the conditions that lend themselves most readily to psychologic analysis Freud's discoveries began with the hysterias, though he and his students went on to the other conditions also, and it is safe to say that most of what we know about the psychoneuroses has been learned from the methods of study and treatment devised by the psychoanalysts Many psychiatrists do not accept the Freudian doctrines, and others believe that they apply in some cases but not in others; but few of them will deny the Freudian insistence upon the early years of life as important in the formation of neurotic personalities Heredity seems of importance, since neurotic patients are more than likely to come out of neurotic families On the other hand, this may be a sort of "social" inheritance, the child's tendency to neurosis may be put into him by a neurotic mother, or may grow up in response to mishandling by a neurotic father This is not the place for a discussion of the Freudian theories of early childhood development, suffice it to say that, according to them, the first four or five years of life are all-important to each one of us. The infant's relations to its parents, especially the mother, its experience in nursing, weaning, learning control of its body functions, adjusting to older brothers and sisters or the arrival of a new baby, are fraught with tremendous consequences for its entire future If it be objected that these are universal experiences, the reply is that they are never identical No two children, even in the same family, ever have exactly the same environment or the same treatment. Parents are for the most part ignorant of the child's psychologic needs and are unconscious of their own often hostile attitudes toward it The emotional security in which alone normal development can take place is all too frequently absent, or at least not consistently present So the child, in its struggle to find its place in its world (the family) too often develops personality twists that are not outgrown, wrong emotional habits such as fear, hatred, anxiety, which persists into adult life, or builds up defenses and finds methods of escape that become the pattern for its future behavior.

This point of view has found much to confirm it in the researches

of the anthropologists and the child psychologists. The more we actually know of early childhood development in our own and other cultures the more we see how difficult is the child's task of making himself into the kind of personality that can adjust without strain to the multitudinous demands of a highly complex society, and the more we realize how few parents understand that the child's emotional needs are as definite and urgent from the moment of birth as are his physiologic needs. All the psychoneuroses, and perhaps all the functional psychoses as well, are malformations of the emotional life and they invariably have their roots in infancy and early childhood

Why, then, are they different? Why do some people develop anxiety neuroses, some hysteria, and some obsessive-compulsive states? Most psychiatrists would answer that there is probably a constitutional basis for the difference People differ in hereditary and congenital make-up Gross differences in physical make-up are easily discerned, even at birth There are long, thin babies, short, plump ones; the strongly formed and sturdy ones; and the delicate ones, who have a hard time to keep alive. How far these differences extend in the internal organs or what differences there are in nervous organization and in the chemical constituents of the body cannot easily be determined. It is reasonable to suppose that they vary greatly in different people Thus, for constitutional reasons, human beings may be predisposed to react in one way or a different way to the frustrating experiences of the formative period of life.

The psychoanalysts do not deny the influence of constitutional factors in the genesis of neurosis. Indeed, Freud himself always postulated them. But according to the psychoanalytic school the particular form the neurosis takes is due to the particular period in infancy in which the frustrating experiences arose whether in the nursing period, the period of toilet training, or the later years of infancy in which the child is attempting to come to terms with its relationship to its parents

However, the important thing for the layman to note in relation to the causes of neurosis is the cardinal fact that they have their roots in infancy and early childhood, and that it is here that prevention must begin. The child nurtured from the beginning in an atmosphere of security and freedom from fear is not likely to attempt to solve his future problems of adjustment by resort to neurotic symptoms.

TREATMENT OF THE PSYCHONEUROSES

Here we can sound a much more hopeful note than in relation to treatment in the psychoses the psychoneuroses are the conditions that are most successfully treated by psychoanalysis and by other forms of psychotherapy The milder neurotic conditions yield quite easily to such treatment, though more severe conditions are likely to need a thorough exploration of the mental life. The compulsion neuroses are the most difficult, and many therapists will not undertake them. In any case, effective treatment of a severe neurosis requires time and is expensive There are no public hospitals receiving such cases, since they cannot be certified as insane, although occasionally, as in the case of B. J, the physicians or a committing authority will stretch a point and declare the patient insane and entitled to care. It is easier in some states than in others to hospitalize neurotic cases. There are always a number of them in the New York public hospitals Psychoneurotics are often desperately in need of hospital care and less able to sustain themselves in the community than some of the actually psychotic But until the public becomes better acquainted with their needs and what can be done for them, the majority will continue to shift for themselves as best they may

Numerous "rest homes" and sanitariums cater to the people who are able to pay. Some of them offer psychotherapy, most of them provide various kinds of physical treatment, baths, physiotherapy and electrotherapy, occupational therapy, and so on Some doctors give shock treatment in neuroses Since psychotherapy is the only form of treatment likely to effect a permanent cure (unless we consider the cases in which cure is claimed by metrazol or electric shock therapy), one need not expect too much from a period of residence in a sanitarium that does not employ psychotherapy, even though many people are benefited by a period away from their homes or usual pursuits

For the poor, there are in a number of the largest cities clinics or outpatient departments connected with the general hospitals This service probably will be expanded in the future, when the lessons learned from the war can be brought home and applied to the citizens at large Clinics of this sort are being developed by the Veterans Administration for the treatment of veterans suffering from neurosis.

It may be asked, "What is the function of the family and friends in these cases? If there are so few facilities for their treatment that

the average person can afford, what can be done by friends and relatives to help the sufferers from neurosis?"

Very frequently indeed the family accepts the neurotic's own valuation of his condition and aids and abets him in it He is ill, they think, or he is very nervous and must be spared any stress or strain. The children must not play with the normal noisy abandon of childhood, for the neurotic mother cannot stand noise They must keep out of the way of the neurotic father, their presence annoys him. The husband must spend his savings or mortgage the future to pay his wife's doctors and surgeons. The wife must go to work, against her inclinations, to keep up the home, since the husband is unable to work. Neurotic men and women often ruin their own lives and destroy the happiness of their homes by seeking a way out through alcohol or drugs Often enough, for the same reason, they are driven into crime. It cannot be too strongly emphasized that *very many unemployables, very many alcoholics and drug addicts, very many criminals,* are fundamentally neurotic personalities, and all attempts to deal with them on the basis of their overt behavior are doomed to failure, since the cause of it remains

Perhaps the best thing that relatives can do is to understand the situation, learn to consider it as not the neurotic's fault and adjust themselves to it so far as possible. All the neurotic's whims and foibles do not need to be catered to. All his irritations and recriminations do not need to be taken to heart When a person has done all that he knows how (or can learn to do) to provide for the sufferer's comfort, he can go on his way with a clear conscience. There is no virtue in sacrificing oneself unduly to something that cannot be helped, and certainly children should not be sacrificed to a neurotic parent

All this can be said in full recognition of the fact that to the psychoneurotic his illness is very real The anxious person suffers pains and attacks that may be terrifying to him, the neurasthenic's fatigue is heartbreaking, the hysteric's pains and aches are as real as anyone's, the obsessional and compulsive states may break the sufferer completely; but that is no reason why families should become involved with the sufferers until they are broken themselves If we are ever to stem the tide of neurotic illness which seems to increase ever more and more as our civilization gets more complex, the layman must learn to understand it as *a form of mental illness,* frequently curable if taken in time and treated by a competent psychiatrist The attitude that it is "only nervousness" and not to be

taken seriously must be overcome. Above all, he must learn that the period of childhood is the breeding ground for the psychoneuroses and that they never will be stamped out until children can be born into families that know how to care for them and train them for normal maturity.

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13

The Psychopathic Personality

After the psychiatrist has classified his patients into the different groups we have been discussing, has made due allowance for the organic conditions and the exigencies of life that cause people to "lose their minds" or suffer nervous breakdowns; after he has ruled out the effects of drugs and alcohol, and the cases for which no actual cause can be discovered, as well as the vast number of neurotic conditions and milder personality disorders, he is left with a large number of people who do not fit into any classification, and whose behavior cannot be satisfactorily explained by any theory of physiologic disorder or psychologic maladjustment so far offered These persons the psychiatrist usually calls *psychopathic personalities*. He will tell you that this diagnosis is a sort of waste basket into which go all the cases that cannot be rather definitely diagnosed otherwise.

The term is confusing, because the word *psychopathic* is used in other ways, as we have seen in the earlier chapters of this book Literally it means *mentally diseased,* and is used to designate the whole group of mental illnesses, as well as to describe a person whose mind is not functioning normally, as when we say "a psychopathic case" Again, there is no general agreement among psychiatrists as to what type of personality should be designated psychopathic Some would limit it to a certain type, which they call the constitutional psychopath, implying a hereditary or congenital condition. The diagnosis "constitutional psychopathic inferiority" was formerly made, a mouth-filling term indeed, but its meaning was always rather vague

The older psychiatrists, including Kraepelin himself, apply the

term *psychopathic personality* to a large variety of maladjusted persons who are not definitely psychotic, nor do they show the classical neurotic features of anxiety, hysteria, compulsions, and so on They are lazy, eccentric, quarrelsome, fanatics, emotionally unstable, "moral imbeciles," vagrants, sadists (abnormally cruel persons), habitual criminals, kleptomaniacs, pyromaniacs (fire-setters), sexual perverts, pathologic liars, swindlers, et cetera When closely studied, many of these cases turn out to be neurotics, unrecognized praecoxes, or cases of simple adult maladjustment—by which is meant the people who never have grown up emotionally and cannot adjust themselves to the world as they find it in maturity There is always a certain number, however, who are neither neurotic nor psychotic, nor are they cases of simple adult maladjustment The psychiatrist has these people in mind when he talks about "the psychopath."

Since so many of these people are antisocial, alcoholic, drug addicts, sexual delinquents, or criminals of various types, they would seem to merit careful psychologic and psychiatric study, with experimental treatment in special institutions. As it is now, they inhabit our jails, penitentiaries and almhouses, or are in and out of institutions of various sorts, costing society vast sums of money, without being cured of their pernicious habits or helped to a better adjustment The layman almost invariably considers the psychopath's behavior his own fault, willfully engaged in, and demands his punishment, regardless of the fact that punishment is the one method that has been tried from time immemorial without ever being effective Until we understand more about the psychopath, until we know the real motives of his behavior, and not merely the reasons he gives for it or the motives that look plausible to other people, we stand small chance of being able to help him

From what we do know of the psychopathic personality, we can say that it is characterized by rigidity The psychopath *is* what he *is*, and, though for a time he may camouflage his real nature or put on a good front, fundamentally he does not change Many things about him suggest the child—or even the infant His distinguishing feature is his egocentricity, he has the extreme self-centeredness of the very young child, and is incapable of any real love or affection for anyone except himself. Nor is he capable of objectivity toward others, he cannot put himself in another's place and realize how his actions may affect the other The world exists for him alone, and anything that interferes with his enjoyment of it or his designs

upon it is pushed ruthlessly out of the way. He has feeling enough, and his emotions are often violent and unstable, but his feelings are always concerned with himself. He may be a braggart and a boaster, inventing great tales of his own prowess and adventures. He often seems to lose all distinction between truth and falsehood, employing either as best suits his purpose, and often in situations where his stories can be easily checked In childhood he is a poor pupil, learning only what he wishes. Unlike the mental defective, who learns, if properly taught, up to the limit of his capacity, the psychopath cannot be induced by any method to learn what he does not wish to It is often said that he is unable to learn from experience. He is the fellow who, having once been burned, braves the fire again, he thinks that this time he will get away with it He may be intelligent, up to the point of genius, or he may be unintelligent, down to mental deficiency. The combination of mental defect and psychopathy produces the *defective delinquent,* who is likely to be a dangerous person because his poor intelligence exercises no caution or restraint over his behavior Some of our more progressive states have separate institutions for this class of defectives, since they are troublemakers in the training schools and cannot be dealt with as the other "children" are.

Perhaps it is not quite right to say that the psychopath does not learn from experience He always learns what it suits him to learn. One of us once dealt with a notorious criminal, who was serving a 99-year sentence in a Federal prison for robbery of the mails. He had behind him a spectacular career, having perpetrated several daring robberies and being an "escape artist," once having succeeded in concealing his identity and eluding the law for eight years. Then he had robbed the mails, and here he was again In discussing the matter with him, he was asked why a man like him, an intelligent and likable chap, could not go straight when he had the chance Why must he repeat his pattern, do the same thing again, even though he knew how high the chances were that he would again be caught?

R G asked us to write the question and give him time to study it. In a few days he sent us a letter containing the answers from eight men who, like himself, were "repeaters." R. G wrote that he had circulated the question among these eight, who he thought might be interested in it They all said the same thing in substance —that they expected to get away with it each time "We try to learn from the mistakes we made the last time," one man wrote, "or

the other times when we didn't get away with it; there are a good many fellows we know who don't get caught We are just the fellows who are not quite good enough "

This type of person really feels that he owes society nothing He feels that it has not given him a square deal, and he sees no reason why he should attempt to conform to its standards

The average psychopath is very unstable emotionally Unable as he is to bear frustration, he "blows up" upon the slightest provocation, or reacts with moodiness and ugly tempers This temper tantrum frequently turns into a real psychosis (called a "prison" or "situation psychosis" because it is so evidently a reaction to a certain situation), when he finds himself in prison He may go into a tearing rage and attempt to destroy everything he can lay his hands on He may sink into a stupor or develop a confusional state in which he is hallucinated and delusional He literally cannot bear the restraint and the confinement of prison life. When sent from the prison to the psychopathic ward or the hospital where conditions are less prisonlike, he may recover fairly rapidly The layman is inclined to think that under such circumstances the psychopath is "malingering," only pretending to have a psychosis However, malingering is rather easily detected, very few people can actually simulate a psychosis The mental disorder in such cases is very real

The relation between psychopathy and genius is stressed by some writers The single-mindedness with which the genius often pursues his course, sacrificing everything—wife, family and friends —to his work, caring for nothing except what he has set out to do, certainly recalls the self-centeredness of the psychopath The life story of many a genius, when truthfully told, reads like the case history of a psychopath The two may be alike in their individualism, their emotional instability and their childish outlook upon life The genius is notoriously childlike, but the psychology of genius is not yet well understood, and it is probably more nearly allied to neurosis than to psychopathy.

Many a psychopath is an attractive person, with winning ways and even charm when he (or she) wishes to use it There is "something about him" that leads people to believe in him, to condone his faults, to keep hoping for his reformation A parent holds on to a psychopathic child, covering his misdeeds and forgiving him "unto seventy times seven " A husband yields to a psychopathic wife, even though he knows her tears are false and that he has suffered tortures at her hands and will suffer them again A wife endures poverty,

wretchedness and even abuse from her husband, but cannot find it in her heart to leave him.

Much has been written about the psychopathic personality, and many case studies appear in the literature Anyone who deals with delinquents and criminals, with behavior problems in school or industry, with the more or less maladjusted on the fringes of our society, or in any situation where large groups of people must be handled—as in the military service—meets the psychopath more or less frequently Not all of them are antisocial. Many live out their lives within the shelter of their families or manage by hook or by crook to keep out of the clutches of the law There are many irresponsible persons, thorns in the flesh to their families and friends, who lack the drive to get into much trouble but show the characteristic rigidity, the egocentricity and the childish attitudes toward life that characterize the psychopath There certainly are mild or abortive cases, who live their lives in a fairly acceptable fashion until some unusual stress occurs, to which they react with the characteristic attitude of "I'll do or have what I want—or else" In short, there are many varieties of the psychopathic personality We may look at a few of them.

SOME DIFFERENT TYPES OF PSYCHOPATHS

Mr A. M, who had been a second lieutenant in the Army in World War I, after his discharge assumed the title of captain He met and married a young schoolteacher of good family, to whom he told an interesting tale of his past life, "very briefly," as he said "I was born in China, my father being an Army officer—a West Point man—stationed in the Philippines He sent my mother to Shanghai so that she might have better care than she could get in Manila, and I lived my first three years there Then my father died, and my mother and I came back to the States. I had my prep schooling at Groton, then three years at Harvard, but I wasn't getting what I wanted in economics and history, so I went to Berlin and got my degree there. My mother remarried and my stepfather got all her money, and I had to come home. Naturally, since my father and my grandfather had been Army men, I joined the Army There you have my life history I don't remember my father, but he wrote monthly letters to me from the time I was born, in which he set down rules by which I have tried to guide my life"

The wife could easily have checked up on this story, but she ac-

cepted it and him for better or worse. It proved to be very much for the worse. He was attentive and loving, told great tales of the jobs he was about to get, but he never earned a penny, and it became necessary for her to support him and the growing family. Mr M made friends easily but held none of them He always had grandiose schemes on hand, but never put them into effect On more than one occasion he forged checks which the wife in some way or other made good, so that he was kept out of the penitentiary He drank more and more heavily, turning night into day, so that his family seldom saw him until dinnertime. He continued to be suave and kind to his wife and family, apparently devoted to them, without ever contributing anything to their support Several times his wife attempted to leave him, but always he found her, and with tears and threats of suicide persuaded her to return to him Kidney disease, aggravated by alcohol, finally ended his career at the age of thirty-eight

This man's whole life was a tissue of falsehoods The truth of his childhood was that both parents were servants in a wealthy family, the father serving as coachman for a year or two, but deserting the mother when A M was an infant She knew nothing of his whereabouts until she was informed of his death in the American Army in the Philippines Upon this slender thread of fact A M. had strung his elaborate fancies He had grown up in Buffalo, with a stepfather (who was very kind to him) and left school in the seventh grade He was, however, a bright youngster, according to his teachers, but refused to study things he did not like He was a voracious reader and had a store of miscellaneous but poorly organized knowledge. In the early teens he began stealing, having always taken what he wanted from his mother and stepfather He was tried on several jobs but could hold none of them He appeared in juvenile court more than once, but his mother always managed to keep him at home In the late teens he became a man about town, spending large sums of money whose source was unaccounted for until it was discovered that he had forged his stepfather's name to several checks, gambling with the proceeds and making large winnings This time his stepfather was wrathful enough to let the law take its course, but in the meantime the young man was called into the Army and, in the hope that it would be good riddance, the charges were dropped and he was adjured never to show his face in Buffalo again He had been a member of the National Guard with the rank of second lieutenant, and he managed

to survive in different camps in the South for the duration of the war Thereafter he was "Captain" M , and his Army experiences grew in number and proportion in his imagination each succeeding year

With variations according to intellectual and educational status and the circumstances of the person's life, this is a typical case. Fantastic lying, swindling and forgery are common means taken by the psychopath to get what he wants.

Mrs. C H is a psychopathic woman who was admitted to the hospital at the age of fifty-two with a diagnosis of alcoholism. She was a strikingly good-looking woman, impressing all who saw her as a very superior type. She had a long history of alcoholism, with many "cures," residence in sanitariums, and so on, till the family's patience and money were exhausted. After the parents' death the sisters and the brothers had refused to support her any longer, and she was admitted to a State hospital Her intelligence was well preserved, but she had no emotional appreciation of her situation She smoothed over her behavior, giving very plausible explanations and telling a story that had small resemblance to that given by the family According to her, she had lived a blameless life and had begun drinking only a few years after the death of her husband. She had held very responsible positions, so she said, and had only occasionally drunk to excess, when her loneliness became too great to be borne She was very bitter toward her family, who, she said, had hospitalized her merely through spite because she would not let them "run her affairs."

As a matter of fact, Mrs C H had had a career of delinquency, beginning in early adolescence The other children had all grown to maturity normally, though one brother developed a neurosis in middle life Mrs H had been a willful, stubborn girl, who always had her own way, was given to impulsive behavior and, though she was considered the "brightest of them all in school," she frequently played truant and only reached the eighth grade At fifteen she ran away from home with an older boy, but was found and brought back before the marriage they had planned was carried through She soon ran away again, apparently alone, and was found some months later working in a factory in New Jersey She declared that she was married and refused to return home The parents, fearful of publicity, did not force her, but tried to keep in touch with her It developed that she was not married but was living with a much older man She left him after a while, and for an interval of a year or two

made her own living and appeared to be much more stable. She soon began drinking, and for a number of years was best described as "alcoholic and promiscuous" At thirty she married a man who himself was an alcoholic and for ten years she nursed him through one spree after another, while drinking very little herself After his death she began again, and for the succeeding ten or twelve years she was usually under the influence of liquor. When she was sober, she was a good practical nurse and had no difficulty in supporting herself. However, she was as her parents said, "bossy," and if she could not have her own way with a case, she would walk off and leave it, no matter how critically ill the patient was

To cite a somewhat different type, we may take a glimpse at Mrs B. F, who was admitted to the hospital at sixty, recovering from an overdose of veronal, which she had taken while in a temper tantrum

Mr. and Mrs B F were wealthy and socially prominent people The night before the veronal episode, they had attended a reception for some visiting diplomats, and the husband had been rather too attentive, so Mrs B. F. thought, to the beautiful wife of an Embassy attaché She herself had flirted outrageously, according to her husband, who felt that, even at sixty, she was an uncommonly handsome and attractive woman, as indeed she was On the other hand, Mrs. F would not allow her husband the privileges that she claimed for herself, and when they reached home she began to upbraid him In telling the story, the husband tried to take the blame upon himself, but evidently there had been a violent quarrel, in the midst of which the lady locked herself in the bathroom, after threatening to end it all When after a half hour she had not reappeared and her husband could get no answer from her, he aroused the butler, who broke open the door and found Mrs F. huddled on the floor in a stupor The husband was so upset and so convinced of her "temporary insanity" that he was anxious to discuss the whole story with us, which he probably would never have done otherwise

Mrs B F had been a beautiful girl, willful and spirited, the only daughter of wealthy parents, who never had understood her or been able to manage her She always seemed to be in trouble with governesses and tutors and was sent to a fashionable girls' school, where she refused to stay, and demanded to be taken abroad She did spend a year in a school in Belgium, and another in France, but insisted on returning home at sixteen She could not be formally brought out for a year at least, but she managed to meet several

young men, among them Mr. B. F., whom she decided to marry, and her engagement was announced at her coming-out party

Their long life together had been a strenuous one. The husband was fatuously in love with her and remained so, his inability ever to feel sure of her attitude toward him probably doing its part to keep him interested Mrs. F never had seemed to care so much for anyone as for herself and refused to have children on the ground that it would ruin her figure She had no intimate women friends, even her mother declared that she could never get close to her, either in childhood or in later life She was a notorious flirt, and on one occasion left her husband for another man, but came back in two weeks, calmly taking forgiveness for granted "You can't deny her anything," her husband said, "she's like a child, a sweet and petulant child who's just bound to have her way You don't know how winning she can be when she wants to"

As she grew older she became more unreasonable, and her temper tantrums increased in violence Once she had locked her husband in his room for twenty-four hours without food or toilet facilities Another time, in a rage at him, she had piled paper in the middle of the floor of his room and set fire to it, almost burning the house down She had threatened suicide a good many times, but never had attempted it before

During the weeks that Mrs. B. F. remained in the hospital she was given tests and personality studies and a number of interviews to determine as much as possible of her personality make-up There was no apparent defect in the intellectual sphere, and in spite of her scrappy education she rated high on intelligence tests Personality tests all showed her to be very self-centered, with a restricted field of interest and little of what is usually called moral sense. She displayed no feeling of responsibility toward her husband and was rather pleased at the predicament in which she had placed him She had no explanation for her behavior, waving it airily aside as "just too impulsive, I guess" In short, she was a self-centered, egotistic child, in spite of her sixty years

It may be thought that a person like Mrs B F was merely a spoiled child, whose husband had continued the spoiling, but the childishness was too deep seated, and her incapacity to develop any real affection for anyone too marked She was an emotionally stunted individual, no matter what the cause.

There is another type, not so frequent, but well known to the criminologist, in whom the traits of stubbornness, egocentricity and

general viciousness seem to be raised to the nth degree. Their histories show that from infancy they have displayed the traits of "adamantine stubbornness, temper tantrums, utter selfishness, complete egocentricity, viciousness, sadism and a total lack of capacity for any substantial postponement of gratification"* They have regard for nothing and nobody They can commit fiendish crimes without a qualm and die defiantly or with curses on their lips The total lack of the common human attributes make this kind of person appear to many people as "dangerously insane," but he does not fit into any diagnostic category or display the symptoms agreed upon to mark the psychotic person He is keenly in touch with reality and often displays a cunning ingenuity in dealing with it He seems to be an evolutionary sport who is hardly a human being, even though he has the semblance of one.

The induction of millions of men into the armed forces raised the problem of the psychopathic personality and the means of its identification. Military authorities unanimously agree that though very occasionally such a person finds in war a socially approved outlet for his aggression and does adjust to the service, in the great majority of cases the psychopath is a nuisance, a troublemaker, or a menace to the morale of the service and he is not inducted, or, if he does get in, he is discharged as soon as his condition has been discovered.

CAUSES OF THE PSYCHOPATHIC PERSONALITY

A number of theories have been advanced as to the causes of this condition. Many psychiatrists believe that there is always a large constitutional factor, or that heredity plays a predominant part. Others find that heredity is not especially significant Dr Sydney B Maughs, who made an intensive study of ten cases at Saint Elizabeths Hospital that had been diagnosed "without psychosis—psychopathic personality" found that in the five cases who were arch examples of the type neither heredity nor environment seemed to play a predominant part† In Dr. Heaver's study‡ one-half of the entire group had forbears who displayed psychopathic traits Still more striking was the finding that only two mothers out of the

* Heaver, W Lynwood A study of forty male psychopathic personalities before, during, and after hospitalization, Am J Psychiat **100** 343, 1943

† Maughs, Sidney B A concept of psychopathy and psychopathic personality, J Criminal Psychopathology **3**.494–516, 664–714, 1942.

‡ Heaver, *ibid.*

whole group of forty appeared to be well adjusted. The other thirty-eight were "obviously inadequate and poorly adjusted women." Other studies agree that early childhood environment may have much to do with the production of the psychopath In the histories of these people, broken homes, poorly adjusted parents, alcoholism, mental disorder of one type or another, criminal behavior and similar conditions occur over and over. Many times there is a parent with psychopathic traits, which merely seem intensified in the child

The psychoanalysts find the cause, in some cases at least, in the hostile and destructive aggression which they believe to be a trait of every infant, through unwise handling it is not overcome or diverted into normal channels. Workers with children stress the role of parental, and especially maternal, rejection The child who has no experience of love, who spends his infancy without any satisfactory relationships with another person, does not learn how to love or to feel with another He knows only his own inner drives and the necessity of satisfying them in any way possible His personality will develop around himself, and he necessarily becomes egocentric Upon such a foundation the various other psychopathic traits will naturally develop.

In this, as in others of the mental aberrations, we do not know enough yet to be sure of all the causes that may enter in to produce the condition It is safe to say, however, that the individual who has a happy and well-adjusted childhood seldom, if ever, develops into a psychopathic personality

TREATMENT OF PSYCHOPATHIC PERSONALITIES

The psychiatrist is apt to consider the psychopathic personality a poor risk for treatment. The majority take a rather hopeless attitude and refuse to have anything to do with him If he gets into the hospital, he is usually discharged as soon as possible as "without psychosis" When he does have a psychosis, it usually can be trusted to subside in a hospital atmosphere, and he is then returned to prison or discharged to relatives or into his own custody. The mental hospitals are not set up to care for the psychopath. He is a troublemaker there, as the psychopathic defective is in the training schools for the feeble-minded. Yet he frequently cannot behave himself well enough to remain at large in the community If he commits major crimes, the penitentiary cares for him, where, as we have

noted, he frequently becomes psychotic. The majority, however, do not commit major crimes. They are alcoholics, drug addicts, prostitutes, petty thieves, in and out of the jails No institution has as yet been developed to receive these people, to keep them securely segregated from society at large, to provide them with all the possible outlets for their energies—sports, games, work, recreations and hobbies in what they can or will engage—and to see to it that they conduct themselves in as nearly normal a fashion as possible For the antisocial psychopath such an institution would be frankly custodial. Many of them might never be able to adjust in the community, and their residence would be life long However, they could be self-supporting, and experimental psychiatry might be able to discover a way to help them to an approximate adjustment.

In a few instances psychoanalysis or some other form of psychotherapy has been attempted with the psychopath. Some successes have been reported,* especially with the milder cases or those in which there are neurotic features With the true psychopath it is almost impossible to establish rapport He is more than likely to utilize the relationship with the therapist as a means of furthering his own schemes, or he refuses to recognize that he has any problems or that there is any way in which the therapist can aid him

The layman may ask, "How early in life does the psychopath identify himself?"

As may be inferred from what has been said, the more severe types show their peculiar characteristics in childhood, even in infancy The child who shows extreme stubbornness and refusal to learn, with aggressive insistence upon his own way, or the unteachable child who, while undeniably bright, may yet act with no more "sense" than the mental defective, who, as he grows older, is entirely selfish and displays no affection for anyone, may be suspected of being headed for a psychopathic career The symptoms and the behavior that these children show as they grow older are numerous, they may learn to camouflage their real nature for a certain length of time, to flatter, to promise, to pretend, or they may develop along more aggressive lines Others may not show the more truly psychopathic traits until adolescence, though the history practically always reveals maladjustment, more or less severe, in childhood It must be remembered, however, that it is not the overt behavior that is of so much importance as the attitude of self-cen-

* Aichhorn, August Wayward Youth (especially Chap 8, "The Aggressive Group"), New York, Viking, 1935

teredness and the lack of normal love attachments. Again, we must note that psychopathic behavior in childhood, such as emotional instability, temper tantrums to the point of murderous frenzy, stealing, setting fires, aggressive sex behavior, and so on, may be due to an organic brain disease, such as encephalitis, epilepsy, or brain injury, and we should not jump to conclusions without thorough physical and mental study When a person suspects that he is dealing with a psychopathic personality in the making, he should, if possible, have expert psychiatric advice

Young people, perhaps, more than anyone else need to know the earmarks of the psychopath and to learn to avoid him. Marriage with such a person almost invariably means trouble and, regardless of the factor of heredity, the child brought up with a psychopathic parent has a poor chance for normal development.

The psychopathic personality is a challenge not only to the psychiatrist but to all thinking people as well. Since the old method of dealing with him as a responsible human being has failed, we must be willing to try other methods, even though they are frankly experimental, nor must we be afraid to embark upon a long-term program The psychopathic state is pre-eminently a life-reaction disorder, and any measures that have a chance of success must take account of that fact The problem of the psychopath is as much social and educational as psychiatric, and no method of dealing with it can hope to succeed without the active co-operation of the intelligent layman.

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Mental Aberrations and War

At present the entire world is recovering from a war more devastating, more terrible, more unimagined in its consequences than any war in history, and from its aftermath Not only combatants, but civilians, women and children, the sick and the infirm and the old, have been intimately involved in it Even in this country, far removed from the scene of combat, the stresses and strains that war engenders were immediate and marked. The right of the individual had to be subordinated, even more than in times of peace, to the welfare of society Everyone, civilian and soldier alike, was expected to tolerate more stress than he had before. Problems of adjustment were numerous and serious In time of war, the mental as well as the physical health of both the civilian population and the military forces becomes of great concern to those charged with maintaining efficiency and morale and is of concern to every intelligent and well-informed layman as well.

EXTENT OF THE PROBLEM

War demands an immense psychiatric toll At present over 60,000 veterans of World War I are receiving compensation of approximately $60 per month for psychiatric disorders which have been legally determined to be due to their service in that war This number is equivalent to about 1 7 per cent of all living veterans of World War I It has been reliably estimated that to date the cost of compensation and hospitalization of the psychiatric casualties of World War I is over $1,000,000,000, and that furthermore the peak

of admissions to Veterans' Hospitals of those servicemen has hardly been reached. over 29,000 are now patients in mental hospitals

The indications are that, although the rate of rejections by Army induction centers for psychiatric defects was substantially higher in World War II than in 1917–18, the incidence of mental disorder in the armed forces was likewise higher; in fact, Strecker and Appel* state that in the winter of 1944–45 nervous and mental disorders accounted for 50 per cent of all Army discharges for disability Does this mean that the present generation is more unstable than the last? Not necessarily It is perhaps not strange in view of the increased violence of warfare, the marked increase in mechanization and speed of movement, as well as the vast variety of places in which the war was carried on, yet, on the other hand, it had been hoped that the process of selection might be more effective and might thereby bring about a decrease in the incidence of nervous and mental breakdown. This hope, for several reasons, has not been realized.

Let us consider first the soldier It is a truism that many factors in military life are far different from those found in civil life These factors call for an active process of adjustment, and it is not strange that some men find themselves unequal to the strain and manifest it in varying psychologic reactions The loss of individuality, for example, and the failure to have an opportunity for self-expression constitute a decided threat to the ego of the individual. Homesickness is likewise a potent factor, perhaps one of the most potent in the development of neurotic manifestations One English writer has attributed war neuroses in very large measure to the undue dependency of the serviceman upon his home and the development of what he terms "separation anxiety" Situations such as those found in the military services in which groups of men are far removed from normal companionship with the opposite sex contribute to the development of conflicts over homosexual trends. One may also enumerate the loss of privacy, the monotony of camp life, the lack of accustomed luxuries and particularly the change in the conscience or ego ideal The need to consider oneself a killer, to go contrary to the teachings regarding others which have been inculcated in one from youth often develops feelings of guilt that may bring about conflicts In this country, at least, as well as in

* Strecker, E A, and K E Appel Psychiatry in Modern Warfare, New York, Macmillan, 1945, p 12

most other civilized nations, we have literally not raised our boys to be soldiers.

When a soldier goes from the camp to the field numerous additional stresses are brought about, such as fatigue, exposure, loss of sleep, a sense of isolation, poor sanitation, anticipation of physical injury or even death, various terrifying experiences, hearing bombs exploding, seeing comrades killed, and so on His mental health is singularly dependent upon the morale of the group and his relationship with the other members of the group, as well as with the commander. If, as for example at Dunkirk, a retreat becomes necessary, a sharp rise in the number of cases of mental breakdown is noted

It should not be felt that all of the effects of war are destructive psychologically, even though from this point of view the balance is inevitably on the debit side In war, life, whether in the field or among civilians, is lived at a higher pitch, and the depths and the peaks are respectively lower and higher There is a feeling of exaltation or devotion to an ideal, a conviction that one is fighting for something worth fighting for; people are drawn more closely together and there is a greater sense of interdependence The soldier feels himself part of a closely knit group and benefits by the support of his officers and comrades All of these are constructive factors and serve, to some extent at least, to neutralize the hazards that have been enumerated above.

MENTAL BREAKDOWNS IN WARTIME

It is an interesting commentary on the reluctance of many of the laity to admit the existence of mental disorder that various euphemisms spring up, especially during wars "Nervous breakdown," a meaningless phrase of no medical standing, we seem always to have with us. During World War I we heard much of "shell shock," a term that was given no official currency in this country During the recent conflict several such euphemisms were developed, some were officially recognized as professional diagnoses but have very little permanent standing except possibly as face-savers Such terms as "battle fatigue," "combat fatigue" and "flying stress" are examples of the verbal tribute paid to the bogey-man of psychiatric disorder!

The breakdowns that occur in the military forces during wartime are not fundamentally different from those which have been de-

scribed in the preceding chapters as occurring in time of peace. The exciting factors are unusual, the coloring is that of war, and on the surface the breakdowns may sometimes appear to be in a class by themselves. The situation is far more specific than is usually the case in peacetime, and we can point to it as the precipitating cause The reaction is often more superficial, with the corresponding result that the breakdown is inclined to be more amenable to treatment and to terminate more rapidly than is the case with a breakdown of similar symptomatology occurring in time of peace

By far the most common type of psychiatric breakdown noted—at least in the recent war—among the military falls in the class of the psychoneuroses described in Chapter 12 During World War I the most common type of neurosis was conversion hysteria, popularly known as "shell shock," described in that chapter The patients exhibited certain physical symptoms without corresponding organic damage, such as inability to speak (*aphonia*), loss of sensation (*anesthesia*), loss of motion (*paralysis*), or tremors, and occasionally convulsions, or massive losses of memory (*amnesia*). This type of reaction, for reasons that are not altogether clear, has become relatively less common than during World War I, although it is still far from unknown and constitutes a large number of cases * The most common type observed in World War II was the anxiety neurosis, or anxiety state, a condition that is fundamentally an exaggeration of the mechanisms of fear, both at the psychologic and the physiologic levels. Here we find nervousness and tension, a tendency to be startled easily, disturbances of sleep, particularly with terrifying dreams, the dreams often being repetitions of actual terrifying events, and feelings of formless and intangible fear The physical symptoms include palpitation, difficulty in breathing, attacks of sweating, and all the common physical concomitants of severe fright These symptoms may develop after a period of exposure or other physiologic stress, in which case they usually respond promptly to rest and food

Closely related to the anxiety neurosis is the *effort syndrome*, in which the physical symptoms are particularly referable to the circulatory appartus On slight exertion pain appears in the region of the heart, together with rapid pulse, difficulty in breathing and a feeling of weakness This condition was described soon after the Civil War and was then called "soldier's heart" There are other

* As remarked in Chapter 11, hysteria seems to be a disease of the ignorant, and it is a fact that the sufferers from this form of neurosis are, as a group, the less intelligent and the illiterate.

related groups in which the predominant symptom is physical, although the causation of the symptoms is essentially emotional. For example, there may be symptoms strongly suggestive of gastric ulcer or of dysentery. This group, sometimes referred to as *psychosomatic disorders,* appeared to be more frequent than during World War I, although this is possibly because physicians are now somewhat more alert to the emotional significance of certain symptoms and not so inclined to demand evidence of organic change as an explanation

As for the psychoses, almost any type may develop, either in camp or under combat conditions The most common type is that which in peacetime, at least, would be considered as a catatonic excitement, one of the forms of schizophrenia discussed in Chapter 10 The onset is often abrupt, but the outlook is generally good and often the course is distinctly short Depressions or excitements may occur, and we may find some of the organic types of reaction as well, particularly those due to head injury. Various conduct disorders may develop and indeed are often the signs of an oncoming psychosis or neurosis Particularly significant is a marked increase in the use of alcohol or a developing irritability in a person previously not greatly inclined to react in that manner

It should be pointed out here that fear is a universal phenomenon Any soldier who denies that he was ever afraid is attempting to deceive either his listener or himself. The reason that some men can tolerate fear while others develop a neurotic or psychotic reaction is largely a matter of early experiences and of constitution The greatest injustice that can be done to these men is to assume that neurosis is the equivalent of malingering or feigning illness, or that it is the result of cowardice Anyone, man or woman, may develop a neurosis provided too great stress is imposed upon him or her for too long a period No one is immune It was found, particularly in the Air Force, that there is a point up to which the development of neurotic symptoms can be checked effectively by breaking the chain of stress Flight surgeons, those physicians whose special duty is to care for the fliers, are taught to observe closely the officers and the men under their supervision and to be alert for early signs such as "jitteriness," excessive smoking and disturbances of sleep If, when these symptoms first make themselves evident, the pilot showing them was given a short period of rest (not amid too much comfort or too far away from danger), the process could be reversed and he would readily be returned to duty On the other hand, if he once

developed the usual signs of neurosis, his further usefulness was likely to be considerably impaired

The psychiatrist has often been accused of failure to recognize and reject those persons who will develop breakdowns The military psychiatrist has only a brief time at his disposal—five or ten minutes, often not even so much He does not have the developmental or social history of the examinee, which he has been accustomed to use in civil life, as an aid to diagnosis. The most important factor in the prediction of a probable breakdown is a knowledge of the patient's personality make-up, which often cannot be discovered except from a good history and a lengthy interview The mental defectives can be comparatively easily discovered by means of certain tests, and there have been many attempts to devise tests that would work as well in discovering personality defects. The wonder is that, under the circumstances, so many of the unfits were discovered and eliminated. The magnitude of the psychiatrist's task can be visualized better when we learn that there are at most only about 4,000 psychiatrists in the entire nation

The psychiatrists have not been content to let things stand as they are, and new methods of personality appraisal were constantly tried out during the war In October, 1943, the Selective Service System put into effect its Medical Survey, which covered practically every registrant before he reported for the induction examination It was an extensive program, which effectively enlisted the co-operation of schools, employers, private physicians and any public or social agencies that had had contact with the prospective soldier. This is the kind of information that every psychiatrist must have about his patients, or that every social worker needs about her clients to enable her to be of much service to them There can be no valid objection to such a program in a time of total war, it proved its usefulness

TYPES WHO FAIL TO ADJUST TO MILITARY LIFE

Contrary to what might be expected, the higher grades of mental defectives, provided they are not handicapped also by personality defects, are useful in the military in certain situations There are still, even in modern warfare, many things they can do more cheerfully than their brighter brothers When put in a situation which he has not the capacity to handle, however, the mental defective easily

becomes panicky and a menace to those about him In addition, only a certain number of them can be used.

The person who in civil life has shown such an incapacity for adjustment that he has had to be committed to a mental hospital is obviously a poor risk from the military point of view, regardless of the type of breakdown that he had No matter how well the ex-patient seems to be, the fact that he has broken once is an indication of a personality that cannot stand too much stress, particularly of a military nature. Many of the servicemen who came into Saint Elizabeths and the other Government hospitals had been hospital residents before, but concealed the fact at their induction examination Also, many of these people had broken down in camp or even before they reached camp One recalls a number of cases whose military life had been too brief to involve any special element of strain.

Joe T, aged nineteen, while on the train on his way to camp, began shouting and singing, cursing the Government and the M P who tried to quiet him, and then relapsed into a semistuporous condition in which he remained even when he reached the hospital Joe, a lanky fellow from southern Georgia, had spent several months of the year before in a State hospital, to which he had been taken in much the same condition described above His parents realized that he had been mentally sick, but thought that he had recovered and that army life would be "good for him"

Those psychoneurotic persons who are unable to carry on a reasonably well-ordered existence in civil life are also poor risks, although a few of them may do well in certain limited situations. Many of them are eager to enter the services, feeling that here they may find a solution of their difficulties Others dread induction, realizing that military life may be too much for them, but fear the ignominy of being rejected and so put their best foot forward and go on

Mr. T. A, a man of thirty-five, the victim of various physical ailments, never had been able to make a living, having been supported by his family; he passed an excellent physical examination and was inducted He assimilated his basic training very well and was sent to a camp in the Southwest where the training was very rigorous There he developed heart attacks and entered the hospital, yet no heart condition could be established, and he was returned to duty Almost immediately he went into a panic and attempted suicide

Again there are types who should not attempt army or navy life,

for they are obviously unable to adjust themselves to it. Tony H., an eighteen-year-old boy of Sicilian parentage, with a sturdy enough body but the face of a Michelangelo angel, enlisted soon after Pearl Harbor because he wanted to serve his country. Tony was a highly sensitive, beauty-loving boy, a dreamer, whose exasperated father, a shoe-repair man, encouraged him to enlist because he thought the Army would "make a man of him." Instead, it broke him completely in a very short time. He came into contact with things which he did not know existed and he was so upset that he went A W O L. He was soon located and returned to camp, where he was placed in the guardhouse to await trial for desertion. Now he was doubly trapped. As he said afterward in the hospital, he couldn't even run away. He went into a state of confusion, in which he saw men as animals, and in his acute excitement he fought everyone who came near him.

All of these cases were unable even to finish training. Others of the neurotic group hold out until they get into combat or into some situation where their personal security is threatened, then they, too, break down.

The alcoholic addict and the psychopathic personality, particularly the type who is rebellious and antisocial, are undesirable persons in the military services, largely on account of their inability to submit to the requirements of discipline. The aggressive type of psychopath may find an outlet for his aggression in combat, if he succeeds in getting so far. But, as has been remarked in Chapter 13, most psychiatrists will not accept him for the service if he can be identified. He is a misfit there as everywhere else. Epileptics, of course, are too great a risk and are automatically rejected if their illness is discovered.

TREATMENT OF BREAKDOWNS IN THE SERVICE

Those men who broke before they had been in combat were hospitalized and might be discharged, depending upon the severity of their symptoms. In many cases, they were "reconditioned" and sent back to duty. Several centers were established in which the man disabled by mental unfitness was recognized as being as much in need of rehabilitation as the man who had suffered physically. Now that the war has ended, it is to be hoped that this principle will be extended, rather than the old one of compensation and continued Government care.

In a general way, it may be said that treatment of breakdowns in military service can be more superficial and brief than is the case in civil life The response of the acute neurotic breakdowns is usually good, provided the treatment is prompt and carried out near the scene of the breakdown This is notably true of the combat casualty. many respond promptly and can be returned to duty. As a general thing, the farther toward the rear the man goes and the longer he remains in hospitals, the less likely he is to be of further use near the front, though there are exceptions The men suffering from neuroses in general are segregated early, as there is a certain contagious effect upon their comrades. To see the man beside you go to pieces is strongly suggestive that the same thing may happen to you Food, rest, psychotherapy, a mental hygiene program and sedative drugs—all are effective Many of the combat casualties during the war were treated in this manner and returned to duty. Much, too, was done in the Reconditioning Centers to restore to military usefulness men who previously would have been promptly discharged as a result of their disability

MORALE FOR THE CIVILIAN

We have spoken so far of the effect of war upon the soldier What of the civilian? He, too, had his problems In some countries, he was subjected to vigorous bombing In any event, he likely had relatives in service who were therefore a cause of anxiety. He was subject to numerous restrictions, such as rationing, and to increased taxes, limitations upon travel and telephoning and writing abroad In many cases, he had to carry also an additional burden of work, this being especially true of women war workers, who in the majority of cases still had their homes and families to care for as usual One might expect, in view of the added stress and strains, that breakdowns among the civilian population would have increased during the war, yet such does not seem to have been the case In England, it was found during the European phase of the war that, in general, mental disorder did not increase and that suicides decreased So far as statistics show, this same was true in the United States, civilian mental health remained at least as good as usual What will develop, now that the "let-down" after stress is upon us, is not so certain

In times of stress, it is always easier to forget our individual differences and to co-operate with others. The real test of civilian

morale has been with us for some time already, now that the immediate threat to our national security is over and the return of millions of servicemen has raised new problems, both economic and social and, perhaps above all, psychologic Among all the problems of strikes, shortages and rising prices there still is no more crying need at the present time than for those of us who have remained at home to acquaint ourselves with the different varieties of human personality and the underlying principles of mental health If the postwar world is to be better than that which bred this cosmic catastrophe, it behooves all of us to cast aside our prejudices and find out as much as we can about the causes of mental maladjustments and what can be done toward their prevention.

What are the prospects of the returning veteran who has had a psychiatric diagnosis? In most cases, he is probably about as good as though he had not been in the service at all In other words, we may expect that for most of the mental and psychiatric difficulties of one sort or another we may look for as good an adjustment to the demands of civil life as the man had shown before he went into the service It should be borne in mind that some men never did well, that some men never had the capacity to do well, but the notion that one who has had a neurotic or psychotic breakdown never can make a suitable adjustment to civilian life again is far from the truth and is wholly unfair to the man and to the community

Some men who return will unquestionably feel the need of securing the advice of a psychiatrist in order to enable them to overcome such lingering disabilities as they may have. Outpatient clinics and consultation centers of one sort or another have been developed in a number of cities already, and the Veterans Administration is planning many others. There is no reason why anyone should hesitate to see a psychiatrist any more than an oculist An understanding of some of these elementary facts on the part of the families, the prospective employers and the returning veterans themselves should do much to make the task of the returning veterans an easier one.

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15

Crime and Mental Disorder

WHAT IS CRIME?
THEORIES OF CRIME AND PUNISHMENT
CRIME AND MENTAL DISORDER

No volume like this which deals with the various types of human behavior and their motives could very well fail to give some consideration to what is generally, if rather loosely, termed criminal behavior Although the motivations of conduct are much the same the world over, what constitutes crime may vary substantially from place to place and from time to time. In our society, for example, one of the most serious crimes is the killing of another—*homicide,* as it is legally termed. Yet among certain primitive tribes it is the practice to kill the aging members and the sickly infants Even in our own society it is legal to kill the one who attacks us—that is, to kill in self-defense; it is legal for the executioner to kill the man who has been sentenced to death, and in time of war it is indeed praiseworthy to kill the enemy Thus, even the killing of another human being is or is not a crime, depending upon the circumstances.

WHAT IS CRIME?

Crime is defined legally as "the commission or omission of an act which the law forbids or commands, under pain of a punishment to be imposed by the State in a proceeding in its own name." A crime, therefore, is a wrong against the State, even though a person may be the victim, although the aggrieved may bring civil suit for damages quite independently of the criminal proceeding Historically speaking, public justice is relatively new The Greeks, for example, and the Anglo-Saxons had no public criminal law, the punishment of an offense against another was left to the individual aggrieved The killer of a man might make amends to the deceased's family by payment of a certain sum of money. After the Norman

conquest, the idea developed that there were certain offenses so inimical to the well-being of the group that the group as such should punish them

Thus the criminal law gradually developed Certain offenses were generally accepted as harmful to the State and came to be known as "common-law crimes" Among these were treason, murder, burglary, robbery, larceny and rape. These are the offenses of which we usually think when we speak of crime They were "felonies," a term still in use which now applies to offenses which may be punished by "infamous punishment"—that is, death or a sentence to the State prison or penitentiary In addition, there are numerous offenses of a minor character known as "misdemeanors," usually punished by a fine or a short jail sentence In addition to the offenses known as evil in themselves (*mala in se*), an increasing number have been decreed by statute as being criminal and are known as prohibited evils (*mala prohibita*) All of these offenses, being punishable by the State, are criminal, yet they may not be generally so accepted. This is notoriously true of Prohibition, a glaring instance of an attempt of the law to lead rather than to follow the accepted opinions of the public Overnight, too, it became an offense to violate the ration regulations and other orders of the Office of Price Administration Such violations are offenses, yet when the rationing regulations cease to be necessary and are rescinded, these various acts, once criminal, again are legal Thus certain acts may become or cease to be criminal very suddenly, but a considerable number of offenses are and will continue to be considered serious offenses against the body politic; to these we refer when we speak of crime It is technically criminal to violate the speed limit, but we do not mean the speeder when we think of criminals!

THEORIES OF CRIME AND PUNISHMENT

The law has to deal in categories, not with individuals It classifies certain types of conduct and lays down certain general rules, expecting the vast majority of the public to fall into the expected limits Therefore, by classification one general type of punishment is laid down for a certain type of offense The assumption—a gratuitous one, of course—is that all persons are alike Various theories of punishment of the offender have existed at various stages of civilization. The old *lex talionis*, the doctrine of an eye for an eye and a tooth for a tooth, which is laid down in the Old Testament,

has been widely found in relatively primitive societies, and the doctrine of "deterrence" was developed in the early days of the Christian era Despite the fact that it is basically a rationalization of group revenge, it is still much in vogue The theory is that if prompt and severe punishment is meted out to the offender it will not only prevent him from relapsing, but it will likewise frighten others into virtuous conduct as well. On this theory during the sixteenth and the seventeenth centuries (and even later) hangings were carried out in public, presumably, the more persons who could see the wretched offender hanged, the more virtuous would those spectators become! As a matter of fact, the pickpockets (picking a person's pocket then being a capital offense) were particularly active among the crowds assembled to watch the hangings, so much so that the subject came to the attention of Parliament The deterrent theory is certainly not an adequate one upon which the punishment of offenders can proceed, and the alleged successes of capital punishment in controlling murder rest on unsubstantial ground.

In the eighteenth century an Italian nobleman named Beccaria enunciated the principle that every offender commits his act because he derives a certain amount of pleasure from it Therefore, he said, let us inflict for each act sufficient punishment to overbalance the amount of pleasure On this basis a "cash register" system of punishment was set up which was soon modified, as in the case of infants, children, animals and the so-called "lunatics" It is, however, still too prevalent in the legal mind Later, reformatories and other institutions purporting to be corrective developed, and some emphasis was laid upon the reformation of the offender. Probation, parole and the indeterminate sentence are still more recent developments based upon the principle of individualized treatment of the offender In all the legal theories of punishment the principle upon which they proceed has been that every offender commits his act after a careful weighing of pros and cons, balancing the risk of punishment with the likelihood of escape Lengthy decisions have been written upon the doctrine of "premeditation," as the law terms it.

In reality it is only in a few types of offenses that the pros and the cons are carefully weighed In counterfeiting, for example, in certain frauds and in gang crimes, it is a fact that the plans are carefully made and that the gains are weighed against the risks Among the gangs who flourished during Prohibition, as indeed among others before and since, the gangsters operated under a code far more strict than the criminal law. Under this code the police

were looked upon as enemies, and it was a capital offense for a member of the group to give the police information. The prevalence of murders was notorious, and yet under this code the police were almost always unable to ascertain who was guilty. The Super-ego or conscience of the gangster, in other words, is entirely different from that of the orderly and law-abiding citizen. Conscience is not something that is born in the individual, but something that is acquired from the practices, the beliefs, the attitudes and the customs of the group with whom the individual identifies himself Most persons do not need a criminal law to prevent them from performing criminal acts For the average individual the esteem of his fellow men and the guide of his conscience (which, after all, is the crystallized attitudes of his group) are sufficient to guide his conduct into channels that are generally acceptable.

All those, however, who have but little foresight, who are impulsive and incapable of learning by experience, may by reason of these disabilities find themselves in difficulties with the law Certain types of psychopathic personality may be mentioned as an example There are those who have gone so far as to insist that the repetition of criminal acts in itself stamps the person as psychopathic However, that form of circular reasoning is not generally accepted among psychiatrists The mentally defective are among those who are short on foresight and are therefore rather easily led into offenses Persons suffering from organic damage to the brain, such as the general paretics, and those in the early stages of senile or traumatic deterioration may, by reason of their impulsiveness and lack of foresight, become involved in criminal activities The offender usually justified to himself his offense, either at the time or subsequently through that beneficent activity known as rationalization, this holds true whether the person is to be called normal or abnormal

It has long been recognized by the law that in certain cases the offender, by reason of circumstances beyond his control, was incapable of exercising sound judgment or resisting an impulse to commit an act that is considered criminal The law refers to this group as "insane" and "irresponsible." According to Clark's *Criminal Law*, insanity in its legal sense is "any defect or disease of the mind which renders a person incapable of entertaining a criminal intent Since a criminal intent is an essential element of every crime no person who is so insane that he cannot entertain it is criminally responsible for his acts." The various tests of insanity which have been applied

through the years have depended on the prevailing views concerning mental processes. Unfortunately, the present test was laid down in 1843 A century old, it has failed to keep pace with the advances in the understanding of human conduct Briefly stated, the judges in the famous M'Naghten's Case ruled that to establish a defense on the ground of insanity it must be clearly proved "that at the time the act was committed the accused was laboring under such a defective reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong" At about the same time the American courts laid down what was known as the "irresistible impulse" doctrine—that is, an inability from disease of the mind to restrain oneself even though one may know that one is doing wrong This doctrine prevails in nineteen of the United States and seems to be peculiar to American jurisprudence The so-called M'Naghten Rule proceeds upon the principle that knowing is the only element of the mental life that counts; it omits consideration of the emotional drives and motivations which we now know to be the fundamentals of human behavior. Most patients in a mental hospital would meet the literal requirements of this test, yet no judge would doubt that they were properly considered "insane"! The irresistible impulse doctrine is far more nearly in accord with the facts. The M'Naghten Rule has been severely criticized by legal writers as well as by psychiatrists, but it is still all too powerful in the courts.

An additional difficulty over and above that of the law in setting up unrealistic psychiatric criteria is the method by which information is conveyed to the court and the jury concerning the mental condition of the defendant There are borderline cases, and at times differences of opinion exist among experts The legal procedure is such as to magnify any such differences and to interfere with the expert, however honest he may be, in presenting his views to the court Various plans, such as the appointment of court experts, have been proposed, but the machinery of the law changes slowly The cases in which these differences of opinion arise are really very few, but they are so widely publicized that the public sometimes has the idea that they are everyday occurrences.

CRIME AND MENTAL DISORDER

The psychiatrist has an interest in the motives of crime as he has in all human behavior, but he is far from considering all crim-

mals to be "insane," as the law would term it Fortunately, some statistics are available covering the examinations in the Massachusetts courts for a period of fourteen years under the provisions of the well-known Briggs law, a law that provides for the examination *before trial* of all persons indicted for a capital offense and all those indicted or bound over for trial who have been previously convicted of a felony Of 4,392 so-called "serious" offenders examined routinely, only 693, or 15 8 per cent, were found to be either mentally defective, definitely committable, in such condition that observation in a mental hospital was advisable, or to have other mental abnormalities These were the findings of neutral psychiatrists, free to report the facts; they are far from the popular notion that to the psychiatrist all criminals are "insane" When one considers that the situation which leads up to the commitment of the average mental patient to a mental hospital is some disturbance of conduct, it is perhaps surprising that a larger number of crimes do not appear to be clearly the result of mental disorder

Mental disorders are highly individual matters, and any given individual's psychosis may lead to almost any sort of so-called criminal conduct Many of these offenses, on account of the failure of inhibitions and the development of aggressiveness, involve assaults, homicide, or rape—that is, offenses against the person In a study (reported by Sheldon Glueck) of patients admitted to Matteawan, the New York State Hospital for the Criminal Insane, the schizophrenics ran high in homicide, burglary, larceny and vagrancy, the general paretics had larceny as the most common offense, with burglary a close second, among the alcoholics assault was the most common offense, next to the one which might be expected—public intoxication, the manic-depressives chose disorderly conduct predominantly, the mental defectives had a substantial proportion of homicides, with the other offenses scattering The paranoiac, by reason of his delusions of persecution and his failure to secure what he considers adequate assistance from the authorities to stop these persecutions, leads the list when it comes to homicide A young Syrian, for example, developed the delusion that he was being slandered and that wherever he went messages were being sent over the wires accusing him of various offenses, so that he was unable to obtain employment. The police were tied in with this persecution, and when an officer finally approached him for the purpose of taking him into custody after he had made threats against a wealthy merchant, he shot and killed the officer in the belief that he was about to be killed by the police.

Among sexual offenses the most serious is "common law" rape, as distinguished from the statutory variety.* This offense is often committed by the so-called sexual psychopath, one of the group of psychopathic personalities, who is often a repeated offender if given the opportunity Among those making sexual advances toward children the early senile dements are not infrequently found One may also mention indecent exposure as an offense in the sexual category, which always should suggest the possibility of mental derangement

Larceny may be committed by the general paretic who thinks that he is taking his own property, or the expansive manic who fancies that he is well-to-do One specialized type of larceny which is probably rare is that found in a few compulsive-obsessive neurotics—*kleptomania.* In this condition articles, very often of little value, are taken under the influence of an irresistible compulsion.

Among some of the minor types of misdemeanor, such as vagrancy and prostitution, we are likely to find the simple type of schizophrenia, the mental defective and certain types of psychopathic personality The mental defective may, by reason of his poor judgment and lowered inhibition, be led into almost any type of difficulty by schemers of better intelligence Much has been laid at the door of the mental defective which he does not deserve He is, by reason of his poor economic status and his inability to exercise mental agility, more likely to be apprehended and convicted than his brighter fellow offender, for this reason the ratio of mental defectives among convicted offenders is probably disproportionately high

We have already spoken of the growing recognition of the need of individualized treatment of offenders, and the great desirability from the social as well as the offender's point of view of giving early treatment in accord with the need of the individual, or, if treatment is unavailing, providing for his permanent segregation In the case of the frankly "insane" such segregation is usually possible through commitment to a mental hospital There is a tendency toward the development of institutions for the defective delinquent—that is, the feeble-minded individual who is a persistent offender—and the sexual psychopath, and several states have laws providing for the indeterminate segregation of these groups From the point of view of prevention, the development of special school classes for the retarded, the development of Child Guidance Clinics and early atten-

*In "statutory rape" the girl is under a certain age specified by law, below which she is declared to be incapable of giving valid consent

tion to conduct deviations may be mentioned as psychiatrically desirable. There are, in addition, many social and educational factors which are involved in the prevention of crime and delinquency, and many of these are receiving study at the present time The attack upon the problem of crime must be a conjoined one. The psychiatrist does not have all the truth, but he, as the one who is interested in reasons for behavior, can contribute his share to an understanding of the problem It is highly necessary that the public itself should be educated in the understanding of motivations Crime is a human problem. The criminal is a human being He is not a different order of mankind, but he has his problems and causes problems as well If the public can only be brought to understand these truths, much can be done in bringing about a more enlightened treatment of the criminal, with resultant benefit to society

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16

Psychiatric Conditions in Children

We have already noted, under various chapters, some of the psychiatric problems encountered in children It is only within the last quarter century that child psychiatry has come to be recognized as a legitimate branch of psychiatry in general, and there are as yet only a few child psychiatrists in this country Nor, are there many specialized facilities for taking care of children suffering from psychopathic disorders There are numerous clinics where children suffering from emotional or behavior disorders can be studied, and the parents advised as to the treatment indicated In some of them the clinic itself may undertake treatment, which often means the treatment of the home and the helping of the parents to see their own mistaken attitudes and to do something about them. Valuable insights into personality development have come out of many of these clinics. But if a child is suffering from a disorder severe enough to require prolonged treatment, or if he cannot safely be maintained at home, only a few places will receive him Some general hospitals, such as Bellevue in New York, maintain a children's ward, and if one has enough money, one may secure the services of a few very

excellent institutions where children may be studied and cared for In most cities, if a child is found to be mentally ill, he must go into a clinic or a hospital with adults In the smaller towns and in the country, if any care is provided, it must be in a State mental hospital, except in those cases where the child is an epileptic and the State maintains an institution for sufferers from this condition

This is not altogether because psychiatric conditions are rare in children It is true that the major psychoses, like dementia praecox and the manic-depressive states, are not often found in malignant form before puberty, but many prepsychotic states exhibit themselves in childhood and later develop into full-blown psychoses, an outcome which might, theoretically at least, be prevented if the proper care could be given in childhood There are children who suffer from an organic brain disease who cannot be understood or properly cared for in the average home, and many neurotic children would stand a much better chance for future happiness and adjustment if they could be cared for and treated in an institution adapted to their needs. The dearth of proper institutions for children is due to the fact that we have been slow to recognize that large numbers of them suffer from nervous disorders. The average adult assumes that most children are "normal" and believes that the home and the school are the proper places to rear them to normal maturity This condition exists in spite of the abundant evidence that any number of homes are unfitted for child-rearing and that the average school is not equipped to deal with children who suffer from the so-called nervous disorders

We shall consider the psychiatric conditions in children under several different classifications, though often they are not as clear cut as similar conditions in adults

ORGANIC BRAIN DISEASE

It must not be forgotten that because of his immaturity a child's nervous system is more unstable than an adult's, therefore, during a physical illness all sorts of nervous symptoms may show themselves, only to clear up as the illness subsides In those illnesses affecting the brain itself, intellectual defect or personality disorders are more likely to occur Fortunately, these diseases are not very common, and when they do occur the function of the layman cannot be much more than to realize their seriousness and to obtain the best medical care possible. There are three conditions, however, in which

the resulting personality changes are likely to be misunderstood and mishandled accordingly

Epidemic Encephalitis

Epidemic encephalitis is known to the layman as "sleeping sickness" In young children, up to three or four years of age, the results of encephalitis are usually very serious. Mental development may cease entirely, or even regress, so that the two- or three-year-old who was progressing normally loses his mental attainments and behaves like an infant again. We recall a child of three, the daughter of a physician, who over a period of several months, following a slight cold accompanied by drowsiness, had shown progressive deterioration, and when seen had ceased to talk or to play constructively and appeared to be an idiot. In older children the mental damage may not be so apparent at first, but nervous manifestations of one kind or another may develop months and even four or five years after recovery from the original illness Involuntary movements, "tics" of various kinds, muscle spasms of the eyes, and epileptiform convulsions may persist or develop as the sequelae of encephalitis Quite frequent and perhaps the most often misunderstood are emotional disturbances and loss of self-control, so that the child appears to be "bad" or unruly. Usually these children cease to learn in school and devote themselves to mischief. They may act like mental defectives, but on psychometric examination do not prove to be so, although there exists a large amount of scatter above and below the basal age They usually impress the examiner as being capable of a normal performance if they could control their attention If the school is not aware of the illness or is not familiar with the behavior of postencephalitic children, they may be scolded, punished, or demoted, although their behavior is frequently so bad that the school refuses to keep them at all.

Twelve-year-old Minnie went back to school after an undiagnosed illness of several weeks, in which she had a high fever, was delirious, and slept a great deal From being a tractable, studious child, Minnie had developed into a "holy terror." She refused to study, would not stay in her seat, had temper tantrums, fought the other children and swore at the teacher who attempted to correct her The school disciplined her, her parents punished her severely; but she grew worse instead of better She lied, stole, and ran away from home. Finally she was placed in a mental hospital where, after

several years of ups and downs, she was considered well enough for discharge to her home

Ten-year-old James had a severe attack of "influenza" in 1918. After recovery, he at first seemed to be normal, but developed the habit of sleeping in the daytime and staying awake at night.* He would prowl about the house, awakening his parents and brother and sister, stir up the dogs and get the whole household in an uproar Later he became very restless and overactive, developed "nodding spells" and tics and was unmanageable either at home or school He spent some time in an institution for epileptics, and he was also tried in special schools and a juvenile reformatory. He even was psychoanalyzed for a while He was a bright boy, and most people who saw him, including several doctors, felt that he was "willfully mean " By the time James reached fourteen everyone felt worn out with him, and he was sent to a mental hospital His unusual behavior continued It was hard to place him, as he fought with younger patients and teased and tormented the older ones As he grew older, he quieted down somewhat and was able to spend long vacations with his parents.

A comparatively large number of such cases developed during the twenties, following the epidemic of 1918 Recognizing the condition as one needing special treatment, the Pennsylvania Hospital established what was known as the Franklin School, in connection with the Hospital in Philadelphia, where a number of boys were kept under a hospital regime, with special training and re-education The results were excellent, most of the children recovering enough to be sent back to their homes Time itself seems to be a factor in stabilizing older children who have suffered from encephalitis They usually become less nervous and better controlled as they approach maturity.

Juvenile Paresis

A second central nervous system disorder whose beginning symptoms are frequently misunderstood is juvenile paresis It occurs only in children who have congenital syphilis These children may seem normal for several years, and then somewhere between eight and twelve a progressive intellectual deterioration sets in The child begins to fail in school, loses his ability to understand the school subjects, shows speech defects, becomes careless in dress and man-

* This "reversal of the sleep curve" occurs fairly often in postencephalitic states

ners, loses his sense of right and wrong. The final outcome is usually complete dementia and death

In most cases, however, the child has shown mental—and often physical—inferiority from birth, and the development of the paresis may be vague and indefinite, so that the parents do not recognize much difference in him for some time Cases have been reported developing as early as the fourth year, and juvenile paresis is sometimes diagnosed as late as twenty-one The symptoms, however, are the same

All children with congenital syphilis do not develop paresis, nor does early treatment of a syphilitic child always insure against it Why one child develops it and another does not is not known.

Malarial or other fever treatment, which has been so successful in adult paresis, has not proved so beneficial with children, perhaps because the child's brain is a developing organ, rather than one which has reached maturity and is therefore more susceptible to damage The prognosis is very poor Hospital care is necessary in the later stages of the disease and is advisable from the beginning

Head Injuries

The third condition to be mentioned here is that sometimes observed to follow a head injury. We have already dealt with birth injuries in Chapter 4 Here we are concerned with the history so frequently given in relation to all kinds of mental defect or psychiatric conditions in children "He fell from his high chair when he was just a baby" "She fell on her head on the brick pavement" "He was struck on the head by a baseball bat" Injuries to the brain do occur from such causes, but most psychiatrists agree that they are very much rarer than the layman believes When the physician or the hospital finds no evidence of brain injury, it is probable that psychiatric conditions developing later have been the causes It must be remembered, too, that a defective child cannot take care of himself so well as a normal one, and even though he does suffer injury it is better regarded as the result of the defect than the cause of it.

There are, of course, children who suffer severe head injuries which result in a change of personality There may be headaches and dizziness, explosive temper, hysterical attacks or convulsions, or the child may apparently recover but show great emotional instability, being easily irritated, flying into violent tempers, fighting

and becoming unmanageable at home and school Kasanin,* who studied a number of such cases, remarks on the resemblance to the sequelae of encephalitis. He finds antisocial behavior, stealing, truancy, sexual misconduct, and so on We recall a boy of fifteen who was brought into a children's clinic after an automobile accident in which his head was injured From being a good and studious boy, he had developed into a hoodlum and had attempted to shoot a policeman who arrested him

These, however, are exceptional cases When such grave consequences follow a head injury, there is little to do except to keep the child in as nonirritating an environment as possible with the hope that he may become more stable as he grows older, though he can scarcely be expected to reach the development that he might have attained had he never suffered a brain injury

FAINTING ATTACKS AND CONVULSIONS IN CHILDREN

Children are much more subject to attacks, "spells," or "fits" than adults These may occur in almost any of the so-called children's diseases, especially in whooping-cough. Infections and toxic conditions are likely to be accompanied by convulsions, and in some children any rise in temperature may produce convulsive seizures They are not nearly so common as they used to be, since more children are cared for by pediatricians, and the child health and welfare programs of the Federal government have taught mothers more about the care and the feeding of infants and children

Epilepsy

The convulsions that occur out of a clear sky or when the child has not been seriously ill are more likely to arouse the suspicion of epilepsy A frequent history in an older epileptic is that of convulsive seizures in infancy, then freedom from attacks until puberty or later The point to be made here is that convulsions in infancy or early childhood should not be attributed to "teething" or "stomach trouble" and so on without observation by a competent physician When epilepsy begins in early life the child needs special care, with attention to diet, rest and a nonirritating environment, and parents need the help of the doctor in planning and carrying out such a

* Personality changes in children following cerebral trauma, J Nerv & Ment Dis **69** 385–406, 1929

regime. It is not uncommon to find a child who has been taken to various healers and nonmedical "physicians," dosed with drugs of different sorts, herb concoctions and so on, even having been subjected to operations, not one of which has had the slightest effect upon his "fits" As discussed in Chapter 5, modern medicine has made considerable strides in the treatment of epilepsy, and it is far easier to do something about it when it is recognized and treated early

Children may be subjected to *petit mal* attacks for some time before actual convulsions develop, and they are not always recognized for what they are, since they may take various forms Whatever form they take, the person is always unconscious and afterward remembers nothing about what occurred during the attack.

Walter, in the third grade, had running spells, he would rise from his seat, run across the room until he struck against the wall, then turn around and "look foolish." At first he was scolded, but it soon became evident to the teacher that he did not know what he was doing

Clarence, seven years old, developed the habit of making faces, at the same time twisting his body toward the left As he did this repeatedly when his stepmother was scolding him, she thought he was mocking her and beat him severely

Jennie, ten years old, used to stand still suddenly and engage in a queer little play with her fingers, talking rapidly meanwhile, flecks of foam appeared on her lips. Jennie also had severe convulsions

The attacks may come only at night for some time and may not be recognized or even discovered When a child repeatedly falls out of bed or complains in the morning of feeling tired and sore, it is well to investigate

Chorea, or "St Vitus' Dance"

Sydenham's chorea, known to the laity as "St Vitus' Dance," is often confused with "tics," discussed below. Formerly believed to be a functional nervous affection akin to hysteria, it is now known to be related to rheumatism and rheumatic heart conditions, from which children suffer more frequently than was formerly recognized. It occurs much more often in girls than boys, the most common age for its appearance being the decade from five to fifteen, though adults may have it also

The first thing noticed may be that the child appears awkward and clumsy, drops things, runs into the furniture, or spills his food Children are often enough scolded or punished for their seeming awkwardness Jerky movements develop, the facial muscles twitch so that the child "makes faces," speech may become thick and slurred, and the child may become totally unable to control his movements or to talk intelligently An attack usually lasts two or three months, but occasionally much longer Once having had chorea, the child may have it again, especially if under strain of any sort

One frequently is told that the ailment followed a fright or a shocking experience of some sort, but even if the connection can be well established it is hardly to be regarded as the true cause of the chorea The choreic child is highly sensitive, and Kanner calls attention to the fact that the illness itself is often ushered in by some days or even weeks of "nervousness," when the child shows "increased irritability and excitability"* He may seem like a different child, becoming quarrelsome, crying at nothing, easily upset and frightened During the illness "the outstanding features are a varying degree of emotional instability, restlessness and difficulty of attention The patients are fretful cross, irritable, sensitive, fault finding They often change quickly and without evident reason from tearfulness to hilariousness It is difficult to keep them in bed They are hard to please, and not easy to manage"† Occasionally there are delirious episodes

The care of a choreic child will be prescribed by the doctor, and it is imperative that his directions be followed The period of convalescence is apt to be difficult On the one hand, the child must resume his activities and his school work gradually and without running the risk of too much strain; on the other, he must not be unduly coddled and made to regard himself as an invalid

FUNCTIONAL NERVOUS DISORDERS OF VARIOUS ORGANS OR SYSTEMS OF THE BODY

Children are much more prone than adults to produce symptoms or apparent disorders of one or another part of the body for which no actual physical cause can be found. We all know how easily they

* Kanner, Leo Child Psychiatry, Springfield, Thomas, 1935, p 188.

† Thom, Douglas A Habit Clinics for Child Guidance, U S Children's Bureau Publication No. 135, 1938, pp. 36–37

are made ill or complain of aches and pains in response to some unhappy emotional experience or something they do not wish to do. It is sometimes very difficult to distinguish these hysterical reactions or psychogenic disorders from actual defect or disorder of the organ involved, and a child's illness should not be dismissed as "just nervousness," or a "putting on" to get what he wants, without medical investigation and advice On the other hand, it is not wise to be too disturbed over them, once assured that the trouble is not organic Many a person develops a lifelong habit of semi-invalidism because his parents were convinced that he was "delicate" or "too nervous" to meet the ordinary demands of life in childhood Much common sense and a recognition of what may be wrong in his own attitudes toward life form the best equipment for a parent in dealing with such manifestations in children

Disorders of the Digestive System

Chief among the organ systems of the body affected by these functional disturbances is the digestive system No complaint is more commonly heard by the pediatrician or the children's clinic than that about a child's eating and digestive habits "He will not drink his milk, he refuses all the foods he should eat, if he is made to eat he vomits" "He has spells of indigestion and can't go to school" "If he gets excited he complains of his stomach, and sometimes he vomits" "He is always constipated, and I have to give him a laxative [or an enema!] every single day."

It is easy to see in these instances the results of parental mismanagement, but the connection is not always so apparent Thom* tells the story of a six-year-old girl who, while apparently in good health, was vomiting every morning All attempts to discover the trouble were baffled, until it became known that the mother was pregnant and had been vomiting in the mornings Bessie, a seven-year-old of our acquaintance, a bright and oversensitive child, had what appeared to be a severe digestive disorder She was allergic to most foods, suffered from alternate attacks of constipation and diarrhea, and had "a feeling in her stomach which made her think she was dying" Her uncle, with whom she lived and of whose severe punishments she lived in dread, had identical symptoms Removed to another home and more wholesome surroundings, her difficulties disappeared.

* *Loc. cit.*

Psychogenic vomiting is often enough a protest against something that the child does not wish to do Some children vomit every school morning, omitting Saturdays and Sundays; or they vomit when faced with a task they dread, as an examination The child expresses his disgust with the situation by literally spewing it out of his mouth Many children react to excitement or to harrowing experiences with digestive upsets The majority of such children come from unstable homes, where the parents themselves are ill or nervous, or where the child lives in an unhappy situation The treatment usually consists largely in stabilizing the environment and helping the parents or foster parents themselves to attain a better adjustment The psychoanalysts make a more direct attack upon the problem and work with the child himself, believing that when he is sufficiently adjusted he can handle his own difficulties.

Disorders of the Muscular System

Functional disorders of the muscular system are not uncommon in children and adolescents Mostly they take the form of "tics" or "habit spasms," which are involuntary movements affecting usually the face and the neck, though they may appear in almost any part of the body Such things as blinking, making faces or grimacing, jerking the head or the shoulders, or even the abdomen, clearing the throat or "making a funny noise," swallowing, twitching the mouth or the hands, and numerous other movements, when they are not under the child's control, fall into this category The movements are often mistaken for those of chorea Tics, however, are of a more stereotyped nature They are repeated over and over, in exactly the same fashion

Tics seldom come out of a clear sky They appear in "nervous" or unstable children, in whom there are likely to be a number of other behavior problems. Johnny, at thirteen, developed a spasmodic contraction of the diaphragm, severe enough to be seen easily through his clothes by a person across the room He was the plain and average child between two good-looking and brilliant brothers He was shy and timid, stammered, and was a "great mamma's boy" His mother was very unhappy in her marriage, though she tried to conceal it from the children, Johnny was her favorite.

Kanner* states that among the cases studied by his group of investigators there was not a single one with tics who did not show

* *Op. cit.*, p. 249.

other personality difficulties also. The restless, overactive, excitable child, overconscientious and oversensitive, is likely to suffer from tics.

The tics often seem to be little more than the continuation of habits developed in the first place in response to some irritation or emotional experience A boy's collar is too tight, he stretches and twists his neck while wearing it and continues the movements after the offending garment is removed. A girl is badly frightened by some boys who jump at her from behind a dark corner She begins to jerk her arms and trunk and continues to do so Sometimes the movements appear to begin in imitation of someone else A boy plays with another one who blinks continually, then "catches the habit" from him Such imitative habits, *when they persist,* must not be dismissed as "just imitations of so and so"; they betoken something wrong in the child's adjustment

Scolding and punishment, to which parents and teachers often resort, are of little effect as treatment "He stops one thing and begins another" The more the child's attention is called to the habit the harder it becomes for him to abandon it Nor should he be encouraged to think of himself as "nervous" or sick Sufficient rest, attention to diet, removal of irritations from the environment, which may involve such things as a new teacher or a new school, or the making over of relations of husband and wife on the part of the parents, are steps that may be necessary In severe cases, the help of a psychiatrist or a psychiatrically trained psychologist is indicated

Enuresis

Another functional condition that causes parents and caretakers much distress is *enuresis,* inability to control the bladder Many parents feel that a child should be trained to achieve proper toilet habits by the time he is twelve to fourteen months old, but only about 10 per cent of children respond to toilet training at this age If, however, a child is still wetting himself at three he is considered enuretic A great many children suffer from this complaint, popularly known as "weak kidneys" or "a weak bladder" However, in the majority of cases there is no physical difficulty to account for it. Like all the other conditions discussed in this section, enuresis is a symptom of the child's inability to adjust to his environment,*

* We must except those cases, numerous enough in poor social and intellectual groups, where little attempt is made to train the child Parents often explain that they themselves were bedwetters and expect the child to outgrow it in time.

and seldom occurs alone. Personality difficulties of various sorts are almost always found in the enuretic child. Often he is of inferior intelligence, but again he may be of decidedly superior endowment He is likely to be overactive and excitable or moody and grouchy. In the great majority of cases there are environmental factors that need to be corrected.

Child psychiatrists agree almost unanimously that the cause of enuresis in children is poor understanding and management on the part of parents and caretakers The psychoanalysts see the enuresis as an expression of the child's emotional stress It arises usually in the period (third or fourth year) when he is trying to get his relationship with his parents satisfactorily adjusted Anything that threatens his security with them may bring on any number of behavior difficulties The birth of a new baby, the loss of a beloved nurse, too harsh methods of training, a fancied neglect (or a real one) on the part of a parent, strained relations or open quarrels between the parents, all may act to make the child fear the loss of his parents' love, and the enuresis is a means of getting their attention and reassuring himself

Parents often foster the habit by too much attention to it The anxious mother, who hovers over the child fearing that something will go wrong, the ambitious one, who sets out to train her baby at a few weeks of age; the rigid one, who punishes any lapses severely —all invite the continuance of the habit rather than its cure Even after a child has been dry for many months, emotional excitement or stress may result in his wetting himself either by day or night Every kindergarten and first-grade teacher knows how often "accidents happen" to well-trained children Little Mary Ann, three and a half, who had been dry since two, started to nursery school, and after a few weeks began wetting herself every afternoon The explanation proved to be her admiration for four-year-old Jimmie, who was an enuretic child and wet himself every day at school

Probably no other child "misdemeanor" has called forth such a variety of harsh measures on the part of parents Scolding, whipping, shaming, depriving of privileges, making the child wash his bedding, and sometimes ingenious tortures—all are employed, and nearly always to no avail Nine-year-old Tim wet himself at school as well as at home, his mother, who had conscientiously tried everything she knew or heard of, punished him by making him stand in front of the fire with his wet drawers over his face inhaling the fumes Tim, a miserable little fellow of the moody and grouchy type, was convinced that he was not his father's child, because the father

was so strict with him. Tim did not improve until he went to stay with his grandparents in another city. Here the trouble stopped as if by magic

In treating enuresis the psychiatrist recommends common-sense measures, easing up on worry about the situation, finding out what in the home or the school keeps distressing the child In severe cases, the psychologist, a psychiatric social worker, or the psychiatrist himself may undertake treatment of the child, which almost invariably involves treatment of the home itself, or removal of the child, temporarily at least, to a less-irritating environment

Sex Habits

Another habit about which parents are deeply concerned is masturbation, but since it is no longer considered by the psychiatrist an abnormal manifestation in children or adolescents, we shall treat it only briefly. The earlier period of masturbation, usually spoken of as the infantile period, needs no further treatment than the recognition that it is bound to occur as the result of the body exploration in which all healthy infants engage Neither threats nor punishment, nor an attitude of disgust or horror are appropriate. Distraction of the child's attention, engaging him in some other activity and answering truthfully his questions about his body are the sensible means of dealing with it If the masturbation is prolonged and excessive, or of the compulsive type, so that the child seems to be unable to control his indulgence, he may need the attention of the doctor, but great care should be taken that he does not regard the circumcision or other operation that may be necessary as a punishment for the masturbation In some cases masturbation becomes so tied up with the child's loves and hates and fears that the services of a psychiatrist are necessary, but ordinarily the matter takes care of itself if treated sensibly.

The same is true of the masturbation of puberty Since it occurs in practically all boys and in the majority of girls, frequently in purely spontaneous manner without teaching by others or any knowledge of it in others, it should be regarded only as a normal phase of sex development In normal cases it never comes to the attention of parent or teacher except by accident—unless they go snooping about to discover it! The adolescent who masturbates openly or to such an extent that his genitals become sore, needs help, and frequently is either of defective intelligence or is suffer-

ing from a severe neurosis In that case the masturbation is a symptom of the personality disorder, rather than the cause of it, as was formerly believed

As to the other sexual "problems" that occur in children, none of them need be regarded as signs of depravity or of a mental disorder It is now known that normal children, if not taught differently, engage in sex play and experimentation with each other, and no useful purpose is served by dignifying these activities by such terms as homosexuality or seduction. Only when children become involved with an unwholesome or abnormal adult is there danger of damage to the personality, and when wisely handled they appear able to outride this hazard also [*] The attitudes of parents and other adults to the situation is far more likely to upset the child than the experience itself. The same can be said here as in the preceding paragraph When adolescents indulge shamelessly in sex activities or in the so-called perversions and occupy their time and minds with sex matters to the exclusion of other activities, they are either defectives or in need of psychiatric attention

DISORDERS OF SPEECH IN CHILDREN

Speech defects of one kind or another are very common in children. The age at which talking begins varies considerably Some children use words as early as five months and speak fluently at eighteen months; others do not talk until three or more years of age Nor does backwardness in speech always indicate mental retardation or defect, although, in general, defective children talk later than the normally intelligent Lateness in acquiring speech is due to a number of different causes, among which the emotional one must certainly be reckoned Harry A, who has been for years Professor of Law in a well-known college, did not talk till he was four. Harry was the baby of the family with four older sisters, all of whom petted and babied him and anticipated his every wish. Allen G, now a normal young man of eighteen, was saying words and phrases at fifteen months, when the nurse who always had taken care of him left, he stopped saying anything After several months of being cared for by his mother, he was beginning to talk again, when her illness necessitated her leaving him for a sanitarium. Again he ceased to talk entirely and cried when anyone attempted to

* Bender, L, and A Blau Reaction of children to sex relations with adults, Am J Orthopsychiat 7.516, 1937

induce him to talk Not until he was three, after his mother had returned and he had established security with her again, did he begin really to talk.

Faulty articulation, such as "baby talk," lisping, or inability to enunciate certain sounds, is common in childhood, and many people carry such defects into maturity They are due largely to faulty training, though defects or deformities in the organs of speech may be responsible. Defects in phonation or the quality of the voice sounds may appear in adolescence, especially in boys * These nearly always betoken a personality difficulty Charles H , seventeen years old, swallowed his words and talked as though he were suffering from bad tonsils and adenoids Charles' throat was clear, but he labored under a great emotional strain His voice improved after his worries came into the open and were threshed out with him.

Clarice M., a young woman of twenty-three, had the high-pitched voice of a young child, which fitted almost exactly her stage of emotional development. Clarice had plenty of intelligence, and she finally emancipated herself from a very dominating mother and grew up Her voice required retraining, but she finally was able to speak normally.

Roger T , at fifteen, had a very high falsetto voice, which he retained until he was in the twenties He used it as an excuse to stop school and for his failure to get a job However, it expressed his fundamental personality, for Roger believed that he was more girl than boy He secretly dressed in girl's clothing and fell violently in love with other boys This boy was developing a chronic mental disorder and was hospitalized at twenty-two

The most distressing of the speech disorders is stammering (stuttering). It is very common in children. The number of stammering children in the United States has been estimated at a quarter of a million About one in every hundred school children is a stammerer The condition occurs far more frequently in boys, though girls are affected also It ranges from the inability to pronounce certain letter sounds without hesitation or repetition up to an almost complete inability to talk at all The stammerer may grow ingenious in substituting sounds he can use for those he cannot, or he may talk fluently under certain circumstances—at the telephone, for instance, or to strangers Often he can sing easily

There are many different theories in regard to stammering, and

* We are not referring to the voice changes of puberty, but to the peculiarities that linger after puberty has passed.

the "cures" for it are legion, from the ancient legend of Demosthenes holding pebbles in his mouth and orating to the ocean for audience, up to psychoanalysis Most of them have at least some successes to their credit, which gives us a clue as to the nature of stammering: anything that can be cured by hocus-pocus or by exercises and rituals is not organic. There may be cases in which an organic condition aggravates the matter, but most child psychiatrists now agree that stammering is a personality disorder In the great majority of cases, it begins in childhood, when the child is trying to perfect his speech (from two to five years) Impatient adults correct him, stop him, make him repeat, pronounce correctly, or siblings laugh at him and imitate him. A sensitive child, as the stammerer almost invariably is, reacts to such interference with increased tension and concentration on his manner of speaking, with the result that the stammer, instead of being a transient matter, becomes fixed.

School entrance develops another group of stammerers, many of whom are found to have difficulties in other fields of language as well They are slow in learning to read, they are mirror readers (seeing the letters in reverse order), they cannot spell, they are left-handed There seems to be little doubt that there is a group of stammerers in whom the difficulty constitutes only a part of a whole complex of speech and language difficulties, probably on a neurologic basis In such cases the condition is much more difficult to treat

Other children react by stammering to the stress of the new situation (school), just as others do not stammer badly until puberty, when physiologic, psychologic and social factors combine to set up stresses and strains for the oversensitive child

Heredity is often accused as the cause of stammering, and it is true that in many cases there is either a stammerer in the immediate family or a history of childhood stammering in parents or other close relatives However, it would seem to be more a case of imitation or of social inheritance than of actual inherited defect of the speech organs or the speech centers in the brain Kanner* points out that when the child is learning to talk there is a natural repetition of sounds, coupled with a search for words that will express his wishes and experiences If at this time there happens to be another person in the home who stammers, it is easy for the child to imitate him. With two or more stuttering children in the family, there occurs immediately the thought of heredity, and almost always a parent or a relative can be produced who also stammered.

* *Op cit*, p 317.

Thus the ordinary difficulties of a child learning to talk are exaggerated, and the fear of stammering serves to fix and perpetuate the habit Almost all successful treatment of stammering seeks to relax the fear and the tension associated with it, and this involves the cooperation of the family—often its re-education

Little Anna, a premature infant and who had been slow in acquiring speech, fell very ill with a throat condition at the age of thirty-three months, following which she was operated on for the removal of tonsils and adenoids The nurse insisted that the parents go home, and next morning Anna woke to full consciousness in the hospital and called for her father and mother to find for the first time in her life that they were not there The whole experience was a tremendous shock to her, and thereafter when she tried to talk she stammered badly. The family, guided by a child psychologist, paid no attention to it Not in any way was her attention ever called to her difficulty with words. She was listened to patiently, never corrected or stopped or made to "say it over." In six months the stammering had disappeared completely.

Another child began to stammer at about the same age after the birth of a sister who became more attractive and aggressive than she was. Her parents "worked at" her continually, attempted to make her breathe properly, to stop and think before she began to talk, scolded her for talking too fast, and so on. At the time of entering school Ethel was still stammering badly

The school systems in our larger cities have classes for speech defectives, and a few states have a state-wide program It has been found, however, that no corrective exercises or mechanical drill on sounds are sufficient in themselves to correct stammering in the majority of cases Such measures are indeed necessary, but they must be coupled with a mental hygiene program that takes account of the whole child, including his family background, his school setting, his status in the community (does he belong to a so-called "inferior" group such as the Negro or other outsider groups, does he live "on the wrong side of the tracks," et cetera), his physical condition, and his personality make-up This procedure is followed in the better speech clinics and it is the only one that holds out much hope of success with school children

BEHAVIOR PROBLEMS IN CHILDREN

A large number of more or less serious difficulties in child behavior may be lumped together under some such caption as above,

since they are not due to any organic defect or disorder, but display themselves in emotional upsets of one kind or another, or in socially disapproved or even antisocial conduct. Such things as extreme jealousy or cruelty, temper tantrums, night terrors, anxiety attacks, fears of various sorts—of the dark, of animals, of storms, water, and so on—lying, stealing, playing truant, obnoxious sex conduct, such as peeping and spying, or exposing themselves, cause extreme anxiety to the parents and form the bulk of the reasons for children being referred to the Child Guidance Clinics or the psychiatrist

Parents of an only child or of a first child are likely to be disturbed by manifestations that they learn to accept with more experience Johnnie is extremely upset by the arrival of the little brother or sister His jealousy, which, to be interpreted, is fear of his loss of his parents' love, displays itself in refusal to eat, is vomiting his food, in temper tantrums, in night terrors which necessitate his being taken into his parents' bed, even in sliding clear back into infancy and wetting and soiling himself It is not unusual for a child of even three or four to strike, slap, or pinch the baby, or attempt to drag it out of its basket or off the bed None of this is a sign of infant depravity, but merely that the child senses that here is another creature that for some reason or other is usurping his parents' time and attention When the first child has been unduly petted and spoiled, the reaction is likely to be proportionately more severe. Unwise parents have been known to tease a youngster by pretending great attention to the baby and laughing at the temper tantrum thus provoked. More often they are at a loss to understand the behavior or to know how to deal with it

In attempting to remedy the situation, parents should try not to spoil the child unduly in the first place and to be very careful that he misses nothing of the love to which he has been accustomed before the advent of the baby He is likely to show some jealousy, but if he is not scolded or punished and is made to feel that he has a share in the new baby, the matter will take care of itself in the normal child

Let us remember that three fundamental human needs which exist almost from the moment of birth are. the need for emotional security, for feeling oneself loved and wanted, the need for adequacy, the feeling that one is equal to the demands of one's environment, and the need for self-expression, for finding outlets for the energy that surges within every normal human being The thwarting of these needs is sufficient explanation for most of the untoward behavior in which children indulge When one's security

is threatened, panic ensues (and not only in children), and there is blind endeavor to do something, *anything*, to regain it. When one feels inadequate to cope with his realities, when real or fancied inferiorities force him to the wall, there is in children a blind striking out at the environment, a rebellion that may take forms seemingly entirely unrelated to the situation Children's delinquencies are often enough upon this basis Or there may be withdrawal, submission to one's weakness, a giving up the struggle even before it is begun Many school failures or poor school performances are due to this type of reaction to frustration. "I'll be beaten anyway, so why try at all?" is the child's attitude, often enough unconscious on his part When the child's urge to self-expression is thwarted, we may expect all kinds of "bad" behavior, from resigned unhappiness up to grave delinquencies.

Johnny and Jimmy are playing ball, inventing rules of their own and pretending that they have a full team Dad goes out to show them how to play. He criticises every move they make and ridicules their "crazy rules" Johnny throws down his bat and starts for the house He is severely reprimanded for his "nasty temper" and sent upstairs until suppertime. But instead of staying, Johnny makes a bundle of his necessities, steals into his father's study and takes all the money from his desk, sneaks down the back stairs and down the hill to the railroad track, where he starts out for parts unknown It had happened once too often This child's father was a minister, he was frantic with grief over his son's behavior and had no idea of his own part in it

Not only the home, but the school, sometimes the church or the community, poverty and a dozen other things may frustrate the child's desire for self-expression Before we become too alarmed about any child's behavior, it is well to examine carefully how his needs are being met The clinic and the psychiatrist would get fewer cases if parents could do this intelligently

THE PSYCHONEUROSES IN CHILDHOOD

Children occasionally suffer from the psychoneuroses, and even from the major psychoses, which we shall discuss in a later section. Many writers would lump together all the various reactions we have discussed above and describe the child displaying any combination of them as "neurotic," and it is true that in our adult neurotic and psychotic patients we practically always get a history

of such traits extending back into childhood. But certainly the majority of our nervous children do manage to grow up and adjust themselves to life, even though they fall short of the degree of emotional development that the psychiatrist might consider desirable. There is probably no adult anywhere who would not show some neurotic traits, either now or in his earlier life, if closely examined, and these traits are far more common in children, since children are in the process of learning adjustment.

However, we get in the clinics and in private practice a certain number of children who suffer so severely from their fears, compulsions, or hypochondriac states that they remind one irresistably of the adult neurotic

Obsessions and Compulsions

Obsessions and compulsions of a mild sort are more or less normal in childhood Many childish games make use of rituals in which things must be done just so or the player forfeits his place or some object or possession Young children love to have things repeated over and over and will not allow a word or an accent to deviate from the accepted version The compulsions to touch or avoid certain objects, to count the window panes, to do everything by three's and so on are very common The obsession with sex thoughts, mental pictures and sex words or expressions is so common around puberty as to be almost normal In rare cases it does lead to action, such as cruelty and aggression (though practically never of a direct sexual nature), or stealing, or to ritual acts "so I can get rid of my bad thoughts" When the child becomes unable to control his obsessive thoughts, when they take possession of him and frighten or worry him beyond all reason, we are justified in calling his condition a neurosis, and he should have help at the earliest possible moment

Sadie F , daughter of an alcoholic father and an unstable mother, could not remember when she did not suffer from a large variety of obsessions, compulsions and phobias. She was beset by doubts and indecision, compelled to do things over and over and never felt sure that they were right. She was obsessed with the thought of her dead brother lying in his grave or rising out of it at the Judgment Day. She was obsessed with fantasies of a boy beaten by his father, identified herself with the boy and suffered agonies of remorse and pain with him. She had a phobia of hell fire and performed all sorts of ritualistic acts to save herself from it. She had attacks of rigidity

in which she lay with her eyes rolled up and could not move her limbs. The country doctor said that she was very nervous and gave her "some kind of pills and powders." Sadie was a good student and she graduated from high school, attended a Teacher Training School and taught for a few years. Her obsessions and compulsions changed as she grew older, but did not lessen. She was never able to make an adjustment for any length of time.

Hysteria

As to hysteria, we hear often enough of the hysterical child, which to the layman means the overexcitable and easily suggestible child, but hysteria as a definite neurosis in children is not so often diagnosed nowadays, although there are still certain quarters where almost any unusual behavior in a child is diagnosed as "hysteria."

Children may display all sorts of hysterical motor disturbances, from tremors and tics up to paralysis of a limb or complete inability to speak (mutism). Hysterical fainting attacks are met more or less frequently. Thomas B., a fifteen-year-old boy from a good home, did not like his stepmother and so he lived with his grandmother who let him do as he pleased. He had hysterical heart attacks. Thomas was brought to the Clinic by his father and had no attacks while under observation. Then one day he ran away from the Detention Cottage and hitchhiked his way to his grandmother's. A social worker was sent to bring him back, and when Thomas saw her he went into a tantrum, crying, swearing and declaring that he never would return. Suddenly he collapsed in a heart attack. His pulse was barely obtainable, though his color was good and his breathing regular. The social worker, who knew him, went on talking about catching the train for the journey back, and all at once Thomas sat up and spoke.

"I'll go if you're going on the train, but I won't go in any old automobile."*

In general, it may be said that hysterical states in children, as in adults, may involve almost any organ or system of the body and may deceive the nonmedical (and sometimes the medical) observer into thinking that an actual organic disorder is present. For this reason parents should not take it upon themselves to decide that a child is "just hysterical." Once having been reassured, however, that the smothering spells or the heart attacks, the headaches or the

* Richmond, W. V. The Adolescent Boy, New York, Rinehart, 1933, p. 84.

globus hystericus (lump in the throat) are not organic, it is well not to let the little culprit get away with it. Some psychiatrists point out to him that he is not really sick or going crazy and that his mind is playing tricks on him, his "spells" are saving him from something that he does not wish to do or to face, or serve the purpose of getting something that he wants, hereafter no one will pay any attention to them

In a truly hysterical child, such Spartan treatment is likely to result in a flood of new symptoms, for the one thing that the hysterical personality craves is attention The psychoanalysts see in this the child's lack of security and his bid for affection Other psychiatrists describe the hysterical personality as a strongly extroverted type, with a shallow emotional life, very suggestible, prone to identify with others (as it is usually put, "very imitative"), and little conscious of any deep core of personality within This type of personality, they believe, can be distinguished even in childhood It must be said that the child hysteric nearly always has someone in his environment who is the inspiration or the pattern for his attacks or his disabilities. The striking resemblance of the child's symptoms to those of the adult who serves as his pattern is often remarked. Removal from this environment and the institution of a wholesome physical and mental regime, and especially placement where nothing can be gained by the hysterical displays, often works a magic cure

THE PSYCHOPATHIC CHILD

The psychopathic personality has been fully described in Chapter 13, where it was said to be in evidence in childhood, even in infancy In a sense the true psychopath never outgrows his infancy. To the end he shows the egocentricity, the inability to understand his relation to reality, as well as the inability to bear frustration, that characterize the infant But we must beware of confusing psychopathic behavior with the psychopathic personality itself Children may indulge in all sorts of perverse activities—lying, stealing, abnormal cruelty, bad sex behavior, assaults, and so on—without meriting the diagnosis of psychopath, which is so often tacked onto them There are different reasons for such behavior, and only occasionally is it due to actual psychopathy The true psychopathic personality, in the sense of the person who has from infancy displayed the traits of "adamantine stubbornness, temper tantrums,

utter selfishness, complete egocentricity, viciousness, sadism and a total lack of capacity for any substantial postponement of gratification," to quote again from Heaver's study,* is fortunately rare. When such a personality is actually in evidence in a child, whoever has him in charge should lose no time in procuring expert advice

The children who show undue selfishness (all children are selfish), hate and aggression, as they are found in those usually diagnosed as psychopathic, nearly always turn out to be children whose infancy and childhood are spent under intolerable conditions. Either they are rejected by their parents or they have had very unwise ones who have not known how to give them the security without which no child can get a real foothold in life The world is hostile to these children from the beginning, an uncertain milieu in which they never can find their places They either fight it directly or they learn to deal with it in cunning, underhanded ways

Treatment of such children should be in the hands of the psychiatrist or of other workers psychiatrically trained The success that has been attained in a few instances suggests that these children can be salvaged if the proper personnel can be obtained to live with and care for them The superhuman patience required is beyond the capacity of most people.

MAJOR PSYCHOSES IN CHILDREN

True psychoses, such as manic-depressive psychosis and dementia praecox in children, are rare, but they do occur We have had the opportunity to observe several

Gordon M., a fourteen-year-old boy from a broken home, was admitted to the hospital after a stormy career of several years' duration. He had spells of incorrigibility in school, when he shouted, sang, and tormented the other children, alternating with periods of quietude in which he seemed to be merely stupid At other times Gordon was a good student, and by no means a dullard. At twelve he was sent to an industrial school for younger children, where he continued to behave as before, finally getting into such a state that he was recognized as psychotic and so certified At thirty-four Gordon is still a hospital patient, though he is able to spend a good part of his time on parole The diagnosis always has been manic-depressive psychosis.

* Heaver, W. Lynwood A study of forty male psychopathic personalities before, during, and after hospitalization, Am J Psychiat. 100 343, 1943

Tommy L, colored, was brought to the hospital at nine years of age, in a semistuporous state from which he passed into an excitement in which he was assaultive, tore his clothes and behaved like the usual adult in a catatonic excitement. Previous to this he had not been noticeably different from other children and was progressing fairly well in school. After a while he was better, but never could live outside the hospital. He was a fairly intelligent lad, learning to do various types of work about the institution, as well as to read and write fluently As he grew older he became very rigid and pedantic, secretive about his delusions, and ceased to take any interest in work He is now in the early thirties

In 1941 Bradley published *Schizophrenia in Childhood,* which brings together all that was known up to that time He notes that there appear to be two types of onset of the disease in childhood: the acute type, which comes on suddenly, as in the case noted above, and the chronic type, which has a much more insidious onset. Since, however, when details of the child's early life are obtainable one usually finds evidence of peculiar or *aberrant* behavior very early, even in infancy, one feels that the disease process may have been present very early in life, though it did not come to the attention of the physician until much later We have in mind two cases, one diagnosed at fourteen and the other at sixteen, in which marked differences from the siblings were in evidence in early infancy There was a seeming lack of appreciation of reality and an inability to make contacts with others in the family, so that from the beginning the child's behavior impressed everyone as "queer" or "peculiar"

The outlook for childhood schizophrenia is poor, but Bradley warns against too facile diagnosis. There are other conditions in childhood that have some of the symptoms of schizophrenia but are outgrown or yield to treatment Much remains to be learned about dementia praecox in childhood, and perhaps the best advice that at present can be given to parents is not to be too quickly alarmed, but not to put off seeking psychiatric advice if the child's behavior is too peculiar—especially if he shows a tendency to be seclusive, to withdraw from contacts with other children and to live in a world of his own instead of trying to adjust himself to reality

Child psychiatry is a new branch of medicine Undoubtedly as it develops, more and more insight will be gained, not only into the causes of child behavior, normal as well as abnormal, but also into the beginning of adult maladjustments Its scope must be greatly

enlarged, and many more psychiatrists must be trained and must turn their attention to this period of life. The working out of a comprehensive child-study program, with facilities for parent education as well as for care and treatment of those children needing it, is a matter for the future, nearly all the elements for such a program are already in existence, however, and await only the pressure from enlightened public opinion to put them together into a real effort to conserve our greatest national asset, our children.

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17

Psychiatry and the Layman

Little more than a century ago, when the United States was well on its way to becoming a great and prosperous nation, when railroads were being built and the genius of New England was in flower, a young woman named Dorothea Dix, who had been forced to leave schoolteaching because of poor health, began to teach a Sunday school class for female prisoners in a Cambridge, Mass, jail. Dorothea Dix was not merely a pious woman, trying to do her duty by a group of poor unfortunates; she had great intelligence and insatiable curiosity and she began to look about her What she saw galvanized her into an activity that lasted for forty years, it not only revolutionized the care of the indigent insane in this country but took her across the water to stir up reform in England also Says Zilboorg,*

"The work of Dorothea Lynde Dix stands out as one of the most heroic and most efficient and beneficial revolutions in the care of the mentally sick in history It was performed by one person, a woman, . . whose name in the beginning carried no authority whatsoever, whose influence at the start was nil, and whose immense energy, staggering grit, combative determination, and single-minded enthusiasm were unknown to herself when she first embarked upon her mission to have hospitals built for the pariahs which the mentally ill were considered at that time " She "traversed the whole country. Bad roads, unseasonable weather, poor means of transportation, inhospitable politicians, parsimonious rich, the selfcomplacency of bureaucrats—all this formidable mass of obstacles seemed to her but so many small pebbles on the road, which she swept aside with her energetic broom of conviction and faith, to march on without respite She reached, she broke into, State legislatures, the United States Congress, the English Parliament While she knew disappointments, anguish, even despair, she never gave up and she always conquered "

In 1848 Miss Dix submitted a Memorial to the United States Congress in which she said that she had seen more than 9,000 idiots,

* A History of Medical Psychology, New York, Norton, 1941, p. 382.

epileptics and insane in this country who were "destitute of appropriate care and protection . . . bound with galling chains, bowed beneath fetters and heavy iron balls attached to drag-chains, lacerated with ropes, scourged with rods and terrified beneath storms of execration and cruel blows; now subject to jibes and scorn and torturing tricks, now abandoned to the most outrageous violations."

In those days the mentally ill were largely confined in jails and almshouses, each community being supposed to care for its own indigent and ill Under these circumstances, without adequate supervision or intelligent inspection, with the ideal of legislators to keep the cost of caring for the "lunatics" as low as possible, and added to all this the ignorance and the indifference of the public, the worst abuses prevailed.

Dorothea Dix succeeded in arousing the public conscience. Before her death she had had a hand in founding or enlarging more than thirty State institutions in this country, where the ideas of the more enlightened psychiatrists were introduced and carried out. Although there are still, no doubt, isolated instances of abuse, and though many public hospitals, forced by the legislators "to keep the cost as low as possible," are still little more than custodial institutions, yet the idea of the mentally ill as unfortunate persons who deserve humane treatment and medical care has been since her day ineffaceably fixed in the public mind

Almost three quarters of a century later another layman, Clifford Beers, was instrumental in bringing psychiatry out of the hospital and founding the mental hygiene movement, which in the last thirty-five years has focused the energies of an increasing number of workers, both lay and medical, upon the problems of prevention and the dissemination of knowledge to that end

Clifford Beers knew the problems of the mental patient at first hand, for he himself resided for several years in a mental hospital The story of his illness is dramatically told in his book, *A Mind That Found Itself* In the early years of this century, shortly after leaving college, Beers became depressed and melancholy and attempted suicide He succeeded only in breaking his leg, but he did jolt his family, who had paid no attention to his complaints, into a realization of his mental state, and he was hospitalized After his recovery he thought a great deal about the lack of understanding of the mental patient, even on the part of doctors and nurses, who seemed to have little knowledge of what was going on in the patient's mind What could be done to make people realize that the

mental patient had not become another order of creature but was moved by the same desires and motives as the supposedly normal? How could he use his own experience to aid in the understanding of the mentally sick?

His book was the first answer to these questions, but it was not enough Beers talked it over with his friends and various interested people and also with psychiatrists The result was the founding of a Mental Hygiene Society in Connecticut in 1908, which brought together a number of outstanding psychiatrists as well as laymen from various fields This was the beginning of the Mental Hygiene movement, which in twenty-one years had branches not only all over the United States, but had become a world-wide movement and could hold a large International Congress of Mental Hygiene in Washington

Very soon mental hygiene began to concern itself with prevention As statistics became available, and the appalling number of mental disorders began to force itself upon public attention, causes and reasons and the means of prevention became of paramount importance Before 1930 it was common knowledge that the number of mental patients in the United States equalled the number from all other illnesses combined It is often stated that for every bed in a general hospital there is one in a mental hospital also One person out of every twenty is destined to spend some time out of his life in a mental institution. When we add to these the far more numerous sufferers from neuroses, who are seldom hospitalized, and the sufferers from mental disorders of one kind and another who inhabit our jails, almshouses and reformatories, the imagination is staggered One is almost tempted to remark that in a race of creatures as abnormal as ours seems to be, a world war is a logical outcome

For a while the movement threatened to be almost too enthusiastic and to promise more than it could perform. Gradually, however, it has settled down into a longtime program, the objective of which may be said to be twofold research and education Mental hygiene makes use of all the discoveries that bear on human development and human behavior, and it encourages research accordingly But unless the knowledge so gained can be made to function in human lives, so that people become happier and better adjusted, all the labor is in vain One of the first things that forced itself upon the attention was the fact that adult mental hygiene problems were often difficult or impossible of solution, but that they always

had a history extending back to childhood. Here the trouble begins, and here it must be attacked if it is to be prevented.

In the early 1920's Child Guidance Clinics began to be organized and they have spread over nearly all the United States. Children's clinics were already in existence in the courts, institutions and, in some places, in schools and colleges, but they were usually without benefit of psychiatry and were largely in the hands of psychologists They had done and continue to do yeoman service in child psychology, and we must remember that child psychiatrists were nonexistent twenty years ago, when the National Committee for Mental Hygiene began their training. Nor can we omit the influence of Witmer's Psychological Clinic at the University of Pennsylvania, the first to be organized in this country, and the work of Healy and his associates in the Juvenile Court in Chicago as early as 1939, and later at the Judge Baker Guidance Center in Boston Dr Healy's work laid the foundation for child psychiatry and added immeasurably to our knowledge of maladjustment and delinquency

The beginnings of human behavior were pushed ever farther back. Thom established "Habit Clinics" for preschool children in Boston, Gesell organized the Clinic for Child Development at Yale and began the study of personality development at birth. As the importance of the first few years of life became evident, parental education began to be seen as a necessity The part that the community plays in the development of personality began to be appreciated and is leading to studies of child development in primitive cultures, as well as comparative studies of different groups in our own culture Not all these activities by any means have been under the auspices of the organized Mental Hygiene movement, but all have contributed to its advancement and have conceived of themselves as co-workers in its field.

Recently a wave of books, magazine articles and motion pictures dealing more or less intelligently and fairly with the problem of mental disease has appeared, indicating a wide public interest Various foundations have given large sums to promote psychiatric teaching and research and hope thereby to improve the care and the prospects of the mentally ill—one thinks here of the Rockefeller, the Markle and the Macy foundation, and the Supreme Council of the Scottish Rite Masons (Northern Jurisdiction) The Psychiatric Foundation has been organized to mobilize lay interest, as is so effectively done in the case of infantile paralysis and tuberculosis, for example. Finally, late in the 1946 session, Congress passed the

Mental Health Act, providing for an annual outlay of ten million dollars for research, teaching and the general raising of hospital standards.

The Mental Hygiene movement has been from the beginning under the guidance of psychiatrists, and indeed is often spoken of as extramural psychiatry, but its work is supported and much of it is done by laymen. After all, it is the layman who is most concerned. He must support by his taxes any measures for dealing with the problems raised by mental illness or abnormality, whether those measures be constructive or not, and it is he who, in the community or in his own home, sees their beginnings and suffers from their neglect

When we stop to think about it, we all know that the matter of most importance in any civilization or cultural group is not its wealth or technical accomplishment but the human material of which it is composed The real strength of a nation lies in the quality of its people For the first time in history, we have sufficient knowledge of human nature to enable us to attack its study scientifically and to predict, up to a certain point at least, what can be expected of an individual or of groups of individuals in certain situations We know something of the conditions under which human beings can develop and flourish, as well as those under which development is stunted and maladjustment inevitable An army marches forward on its stomach, according to Napoleon, but it has taken us a long time to see the essential truth in the remark that a nation marches forward upon the feet of its children

As has been stressed many times in this book, psychiatry and psychology do not pretend to have all the answers to the problems of human beings. Many of them must be sought in other sciences—in physics and chemistry, in anthropology and sociology, as well as in the newer science of ecology, which studies the relationship between the organism and its environment Nevertheless, in its knowledge of fundamental human needs and its insistence upon the necessity for their fulfillment, psychiatry has the key to the development of normal personality

In this war against mental maladjustment and mental disease, or, to put it positively, in this campaign for the development of better human beings, for raising the level of our human resources, the layman must play an increasingly important part. Without a body of informed public opinion behind him, the psychiatrist is as helpless as a general would be without an army He can chart cam-

paigns and plan procedures, but the layman must carry them out The doctor cannot force his patients to take his medicines or follow his advice Without their co-operation he is helpless

This book has been written in the faith that the layman wants to know more about psychiatry, and that, rightly informed, he will lose much of his dread of mental abnormalities and be willing, even eager, to join with psychiatry and mental hygiene in helping to advance the campaign for better human beings in a better world

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Superior n ([n]) refers to names which appear in the footnotes